H.E.F. CANADA QUARTERLY

The Human Ecology Foundation of Canada

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THE HUMAN ECOLOGY FOUNDATION OF CANADA

THE H.E.F. CANADA QUARTERLY

The HEF Canada Quarterly is a publication of The Human Ecology Foundation of Canada, a charitable organization under Canadian law, operating on a non-profit basis. THE QUARTERLY is for people who are interested in health and its relation to our environment. It deals primarily with research in the field of clinical ecology (environmental medicine), and also describes how people have improved their health by changes in habits, diet and environment. As such, it does not offer medical advice, and we urge persons wishing to experiment with changes in their lifestyle to do so with the help and guidance of a knowledgeable physician.

THE HUMAN ECOLOGY FOUNDATION OF CANADA

One of the purposes of the Human Ecology Foundation is to promote the free exchange of information on the prevention and treatment of ECOLOGICAL ILLNESS. People who are ecologically ill and/or environmentally hypersensitive are no longer able to adapt well to common and increasing exposures in their everyday environment. They may develop a variety of chronic or acute symptoms that are brought on by substances in the air, in food, or in water.

Natural inhalants such as pollens, dust and moulds, and even natural foods may begin to affect people adversely. This aspect of the condition is often referred to as "allergy", but the many synthetic chemicals that are now common around us can also cause symptoms, and overexposure to these can trigger ecological illness even in those with no history of allergy or other sensitivity to the environment. Symptoms may be mild and merely annoying, or they may become severe enough to interfere with a person's daily activities, family life, and career.

On a local basis, HEF Branches work toward finding sources of chemically less-contaminated food, water, clothing, and household furnishings, as well as providing counselling on changes of lifestyle that may alleviate symptoms. The Foundation and all its branches would like to encourage others to become involved not only in research on the effects of environment on health, but in working toward a healthier, less-polluted environment.

ENVIRONMENTAL HYPERSENSITIVITY IS A CHRONIC MULTISYSTEM DISORDER USUALLY INVOLVING SYMPTOMS OF THE CENTRAL NERVOUS SYSTEM AND AT LEAST ONE OTHER SYSTEM. (Thomson Committee Report 1985).

SUBSCRIPTION AND MEMBERSHIP

Membership in the Foundation includes a subscription to the HEF CANADA QUARTERLY which is published four times per year. Annual membership and subscription fee is $20. WE INVITE NEW MEMBERS!

P R E S I D E N T ' S M E S S A G E

The Ontario Government's THOMSON COMMISSION REPORT ON ENVIRONMENTAL HYPERSENSITIVITY has now been released. Our questions of how, or if ECOLOGICAL ILLNESS would be recognized are here, and reviewed in your Quarterly's first edition of 1986.

Yes WE DO EXIST, but the methods of treatment are under scrutiny. Be positive, our foot is in the door, so let's get it open wide.

We can take a positive approach. Let us promote those things which are good in our environment. If we are asked about our views on spraying - STAND UP AND BE COUNTED! Apply pressure to the government to implement the recommendations of the report.

If you are better, donate some of your time and energy. Much has to be done. DON'T TURN YOUR BACK ON THOSE WHO NEED HELP. Share your experiences. OUR VOICES CAN MAKE CHANGES.

Let's make 1986 "THE YEAR OF THE ENVIRONMENTALLY HYPERSENSITIVE"!

Ecologically yours,

Lynda J. Brooks, R.N.
President
H.E.F. Canada

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The H.E.F. Canada Quarterly is a communications line that belongs to all of us. We welcome your comments and contributions, your articles and inspirations. The deadline date for the June 1986 Quarterly is May 2nd. Don't forget to write.

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REPORT OF THE THOMSON COMMITTEE
ON ENVIRONMENTAL HYPERSENSITIVITY DISORDERS
Summary and Comments
by John K. Blair, M.D., F.R.C.P.(C)

In November 1984, following discussions with Mrs. Margaret Nikiforuk (representing the Parents of the Environmentally Sensitive) the former Minister of Health, Keith C. Norton decided to formally investigate environmental hypersensitivity disorders. Judge George Thomson agreed to act as chairman. Members of the committee were: three specialists in allergy and immunology, Dr. James H. Day, Queen's University, Dr. David R. M. McCourtie, University of Western Ontario, and Dr. John W. Gerrard, University of Saskatoon; also, Dr. William D. Woodward, Professor of Nutrition, University of Guelph, and Dr. Susan Evers of the Department of Family Practice, University of Western Ontario. I do not know how the members of the committee were selected.

The report was given to the Ministry in August 1985, and released to the public in December 1985. The report is 314 pages long, and there is a 200 page appendix.

The committee was asked to report on the present level of knowledge about environmental hypersensitivity, paying particular attention to prevalence, methods of diagnosis, and methods of treatment. The committee was asked to outline possible approaches to investigating, treating or undertaking further research into such disorders.

According to Judge Thomson, the size of the task proved to be much larger than the members of the committee had anticipated. The committee obviously worked very hard in making the report. The many submissions to the committee included letters from 607 patients. Members of the committee visited environmental control units, offices of some Ontario doctors practising clinical ecology, and talked to doctors in the United States, and from Britain. All of these contacts were of some influence on the committee in reaching their conclusions, and the members expressed appreciation to all those who took time out to share their concern, knowledge, ideas and experience.

With difficulty, the committee arrived at a working definition of environmental hypersensitivity. ENVIRONMENTAL HYPERSENSITIVITY IS A CHRONIC MULTISYSTEM DISORDER, USUALLY INVOLVING SYMPTOMS OF THE CENTRAL NERVOUS SYSTEM AND AT LEAST ONE OTHER SYSTEM. Affected persons are frequently intolerant to some foods and they react adversely to some chemicals and to some environmental agents (including natural inhalants - dust, mold, etc.), singly or in combination, at levels generally tolerated by the majority. Affected persons have varying degrees of morbidity, from mild discomfort to total disability. The physical examination is usually normal. No laboratory test is consistently altered. Improvement is associated with avoidance of suspected agents and symptoms recur with re-exposures.

The report outlines some of the key concepts of clinical ecology but points out that these concepts have not been scientifically proven. The "total load" concept refers to the idea that environmental hypersensitivity develops when the patient can no longer handle or tolerate a combined load of physical and psychological stresses. Part of Dr. Theron Randolph's concept of adaptation/addiction is that people can crave and become addicted to the substances to which they are sensitive. With repeated exposures, the body adapts by responding with diminished reactions, and this process is called "masking".

They agreed with Dr. Iris Bell's statement that the individual's tendency toward specific types of medical and/or psychiatric disorders is likely to be a complex function of age, sex, heredity, biological rhythms and nutritional status. "Clinical ecologists emphasize the uniqueness of the individual and of his or her response to environmental stresses."

Although it is often necessary to arbitrate "safe" levels or threshold values of toxins in the environment, there are comments in the Thomson Report on the narrowness of this point of view, and that adverse effects can occur from chronic low-level exposure to some toxins. The dosage that causes adverse reactions may differ in different individuals. Threshold levels may vary from person to person and within any individual, from one time to another. There may be no fully "safe" level of exposure to some toxins with regard to such adverse reactions as mutations and the development of cancers.

The committee could not find anything positive to say about our work with Candida albicans. The concepts about yeast overgrowth were well described, but the committee could not find any scientific basis for saying that yeast overgrowth causes environmental hypersensitivity. They correctly point out that the diagnosis depends on history and a trial of therapy. We do not have any reliable laboratory tests to determine which patients with environmental problems have yeast overgrowth. Double blind-placebo-cross over studies have not been done to scientifically prove that the anti-yeast approach, including Nystatin, helps those patients with environmental problems.

Is it correct to use an unproven approach? It is correct when the approach is used as a "therapeutic trial". There has to be a time limit in any trial, and then a decision has to be made as to whether the trial is really therapeutic. In a meeting in Vail, Colorado in August 1985, Dr. Frank Waickman spoke against unnecessary long term trials of Nystatin. He wants to see some significant improvement with the anti-yeast approach within six weeks, otherwise he questions the role of yeast in the illness. The Thomson committee pointed out that we do not know that Nystatin is absolutely safe when taken for long periods of time. My comment is that no "toxic" effects as occur with some other drugs have been reported, however, we should always be ready to stop or taper off Nystatin when it appears to have done its job.

We all know the risks of long term use of Ketoconazole, and the committee expressed this as well.

Clinical ecologists do not blame environmental hypersensitivity on yeast. We feel that environmental hypersensitivity can be associated with yeast overgrowth, and that yeast overgrowth can increase a person's maladaptation to the environment. At our meeting in Toronto on April 13, 1985, Dr. Sidney Baker said that we should not think of yeast as something that attacks us, then causes illness. Dr. Krop points out that yeast must be considered as a secondary problem; something has to lower our resistance first before there can be any yeast overgrowth. Dr. Maclennan considers problems with yeast as just part of the overall problem with moulds, and he does not selectively go after yeast alone.

We have all seen examples of some wonderful results with the anti-yeast approach, but we have to keep this in perspective, and not let it crowd out other basic approaches. We would love to prescribe something like Nystatin and completely solve a patient's problems. But this is just wishful thinking. The anti-yeast approach is often just a small part of getting someone better, and in many patients it is not relevant at all.

The Thomson committee appreciated the fact that emotional stress can play a role in environmental hypersensitivity. Psychological stress can alter some immune functions. They commented on central nervous system regulation of immune functions, and the new and rapidly expanding study of neuro-immuno-modulation.

Viral infections including infectious mononucleosis were also mentioned as a factor in triggering many of the symptoms we associate with environmental hypersensitivity.

There is a detailed chapter summarizing present knowledge of adverse reactions to environmental agents. Perhaps we can include some or all of this chapter in a future edition of the Quarterly. [We'll try for the June 1986 issue. Ed.]

The report mentioned that the doctors practising clinical ecology were quite open in discussions of their work, and accepted the need for additional research to establish, in scientific terms, the efficacy of many of the tests and treatments now being employed. Although the committee members were impressed with the calibre of medicine practised apart from clinical ecology, they wondered if we were too willing to attribute symptoms to environmental factors. Part of this bias is due to the fact that many of our patients have already been extensively investigated by other doctors without satisfactory explanation of the cause of the problems. Also, most of us feel that the environment can play a direct or indirect role in many different illnesses.

The committee members did not like our dependence on subjective responses by the patients in determining whether a challenge test was positive or negative, or in determining a relieving or

neutralizing dose. They felt that there should be much more use of placebos and double blind testing. I think they had difficulty accepting the concept of neutralization. It is not really logical that a weaker or stronger dilution of a substance can relieve symptoms. Personally, I had to put logic aside in doing this type of testing. It is hard to believe until you find this response over and over again with many different patients. We cannot always neutralize reactions that we provoke, at least not in my office.

With respect to a food that gives a positive test, the committee felt that the test needs to be confirmed by withdrawal followed by controlled challenge or reintroduction of the food. Except when there is a severe or critical type of reaction, I don't think any of the clinical ecologists would argue with this.

The committee recognized the validity of the nasal challenge test for determining IgE sensitivity to inhalant allergens, and felt that this should be covered by the Ontario Health Insurance Plan (OHIP). The use of serial dilution end-point titration for determining treatment doses, intradermal, subcutaneous, and sublingual provocative testing were all felt to be unproven techniques, and further research is required to establish their accuracy. They said that until these tests are proven as accurate they should not be covered by OHIP.

The numerous letters received by the committee from patients (607) convinced them that there are a number of very sick people in Ontario for whom various kinds of support should be available, ignoring any ongoing debate about the cause of their condition. They realized that many patients have been caught in the midst of a growing debate between different parts of the medical profession. The committee also appreciated the great expense involved for some patients with respect to testing, treatment, supplements, safe water, chemically less contaminated foods, and either moving or making their present homes safer. They mentioned the extensive time and energy some patients have to devote to simple management of their lives following a diagnosis of environmental hypersensitivity.

With respect to major and expensive changes of lifestyle, food, water, clothing and shelter, the committee felt that sometimes these measures were recommended too quickly, and that every effort should be made to avoid these changes unless they are absolutely necessary. I often wonder how far a patient does have to go with this sort of approach. Sometimes the answer is not clear at the beginning. Some people are completely better when they stop drinking milk. Some people have to "go all out" in order to get better. We don't want to make anyone neurotic and fanatical about any of this, but unfortunately it is true that some people have to go to great expense and trouble in order to make their environment safer, and get adapted again.

The committee considered the use of elimination diets an effective treatment technique. The rotary diet was well

described in the report, but they were concerned about the complexity, the difficulty, and the nutritional adequacy of very strict rotary diets. They encouraged the support of a nutritionist. They agreed with the use of vitamin and mineral supplements, but not in megadoses.

It is true that the rotary diversified diet has not been formally proven to be an effective treatment, but some sort of rotation is appropriate if a great many foods are not tolerated very well. You can't leave out everything. If it becomes clear that it is the natural phenolic chemicals in foods that cause many of the food reactions, then rotation of foods according to biological families is not really the answer. I hope we can all get a little smarter about this in years ahead.

The committee was concerned about the expense and inconvenience of pure water and organic food. Also, it is difficult to ensure that the foods are in fact free of chemical contaminants. To this I would say that in the present condition of this planet, there is no absolutely pure water or food. It is necessary for chemically susceptible people to at least find out if they improve with different sources of water, and chemically less contaminated foods.

The use of environmental control units was described, and committee members visited Dr. William Rea's unit in Dallas, and Dr. Theron Randolph's unit in Chicago. The committee concluded that such units apear to be helpful in providing both a temporary safe environment for acutely ill patients and a good setting for testing and research purposes.

During their study of environmental hypersensitivity, the committee members developed an increased concern about the role of environmental factors as a cause of human illness. "It seems clear that we are inexorably increasing the toxicity of our environment. Some of those chemicals may not be hazardous. However, it is clear that some are and that, for many, we have no way as yet of knowing whether they are or are not harmful; nor do we have adequate information on the effects of low-dose exposure over long periods or the possible synergistic effects of long-term exposure to many chemicals."

The work of some school boards was mentioned: experimental low-pollution classrooms, the postponing of painting and spraying activities until school vacations, and studies to identify and avoid potentially hazardous building products.

The committee concluded that environmental hypersensitivity does exist, although there is no three word sentence: "Environmental sensitivity exists". The wording throughout the report is very careful. They found it "impossible to estimate, with any degree of precision, the total number of persons in Ontario who have such sensitivities". This is understandable. All of us are constantly adapting to the environment. There is no state of perfect health, but degrees of health in which we are more or

less adapted to the environment and various forms of mental and physical stress. How many people in Ontario are significantly less adapted to the environment compared to the rest of us? Can we ever measure this sort of thing?

The committee acknowledged the growing awareness of the importance of environmental factors in understanding disease. "Concern for the social and environmental context of disease is part of any comprehensive analysis of a patient's condition." A number of doctors "do not sufficiently recognize" some of the environmental factors that can play a role in causing illness. "Some patients complained that their doctors were unwilling to accept even the possibility that foods or chemicals might be implicated in their symptoms." "Knowledge about nutrition continues to be less than it should amongst members of the medical profession as a whole."

The committee appreciated the difficulties patients have with insurance companies, and the Worker's Compensation Board, and the difficulties in getting appropriate Family Benefits or disability pensions. Sometimes the root of the problem is the controversy over the validity of ENVIRONMENTAL HYPERSENSITIVITY as a diagnosis. The Thomson committee concludes that it IS A VALID DIAGNOSIS, so this should help to eventually ease the problem. "As individual doctors broaden their definition of workplace elements that can affect individual capabilities, the number of successful applications to the Worker's Compensation Board increases."

The committee was concerned about unproductive and divisive debate amongst doctors regarding environmental hypersensitivity. They cautioned against anyone taking an absolute stance in this field since there is a great deal we do not know about our environment and its effects on us. There is "a need to develop approaches that bring together all practitioners, however their perspectives differ, and to do so before the gulf between them becomes so great as it now appears to be in the United States."

There were many final recommendations including restrictions on smoking in public places and in work places. They mentioned the difficulty in producing adequate ventilation systems that would eliminate problems from second-hand smoke. They recommended adequate labelling of foods, chemicals, drugs, and other products so that the consumer can better protect himself.

A key recommendation was the development of multi-disciplinary investigative and therapeutic environmental control units. In such a unit, proper research can be done to determine the accuracy and effectiveness of current tests and treatments used in clinical ecology. Both inpatient and outpatient services would be available. The unit would serve a teaching function increasing awareness and knowledge of environmental problems amongst doctors, nurses, hospital personnel and the general public.

"In the event that a unit is not developed, future seriously ill patients should continue getting financial support for treatment in environmental control units in the United States."

Programs of continuing education were recommended "to provide practitioners with the scientific information, which is increasing, that both supports and questions recent, highly publicized theories and beliefs in the field of environmental hypersensitivity."

"All basic social assistance programs, particularly those administered under the Family Benefits Act, should be reviewed to ensure that they recognize how disabled some of these patients are." "They should not be deprived of minimal levels of support because of disagreement within the medical profession regarding the causes of their conditions." "Those who administer social assistance programs should be receptive to individual patients judged to be disabled, while the precise cause of their disability is being established." The doctors who assess people seeking social assistance, worker's compensation, etc., "must have current information about environmental hypersensitivity, and must be willing to assess the patient's condition irrespective of any diagnosis attached to it." "Private insurers should take the same approach in situations where there is a clear disability but some debate as to causation."

With some controls, at least a portion of the costs associated with special diets and prescribed vitamin and mineral supplements should be claimable through existing food supplement programs and drug plans.

The curriculum in medical schools should be reviewed to ensure that issues relating to environmental illness are part of medical education. The students need to know about the growing importance of the environment in the diagnosis of illness, and they need to know about the limits of our present knowledge in this area.

The report concludes with the following statements: "Environmental hypersensitivity involves some key human issues: the fragility of the global environment, the fragility of the personal environment of some particularly vulnerable human beings and, in the possible interplay of psyche and soma, the delicacy of each person's inner environment." "It highlights both the possibilities of science and its limitations."

I feel that Judge Thomson and his committee have helped all of us with their honest and objective review of clinical ecology and environmental hypersensitivity. Just stating that "ENVIRONMENTAL HYPERSENSITIVITY DISORDER" is a valid diagnosis is a big help. Let us use this term, and those of you who have not already done so, should get the term "20th century disease" out of your vocabulary.

The report should keep all of us a little more objective in our work, and help us avoid any preoccupation with any one aspect of environmental hypersensitivity. If you need psychiatric or psychological assistance, then get on with it. If you have too much yeast in your system, then work on this problem at the same time. Don't take Nystatin for prolonged periods of time unless there is good reason to believe that this is necessary. If you know that you are sensitive to a wide variety of foods and chemicals, then do something about it. Do you really have to get this confirmed with challenge tests? Do the least expensive things first. Don't get a new furnace if someone in the house is still smoking. Be as neurotic as you have to be to protect yourself, but don't let this become the main problem. As calm, rational people, let us encourage the Minister of Health to start implementing the recommendations in this report, and not let it just gather dust somewhere in Queen's Park. An environmental control unit would be a good start.

Addendum: In January 1986, the Minister of Health, Murray Elston, appointed Dr. Barry Zimmerman, Chief of Allergy and Immunology at the Hospital for Sick Children in Toronto, to chair a committee to review the Thomson report, and help the Minister decide whether to act on its recommendations. Dr. Zimmerman is well respected, and his recommendations will have a strong influence on the Minister of Health. However, Dr. Zimmerman will have to overcome a strong bias he has against environmental hypersensitivity if he is to be as honest and objective as the members of the Thomson committee. As a scientist, he will surely see the value in establishing an environmental control unit to properly study environmental hypersensitivity, diagnosis, and management. We will hope for the best.

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EDITOR'S NOTE:

Dr. John Blair practises Internal Medicine and Clinical Ecology in Guelph, Ontario, and is on the executive of the Canadian Society for Clinical Ecology and Environmental Medicine, and the Human Ecology Foundation of Canada. Because of the importance of the Thomson Report, excerpts from the Waterloo-Wellington Branch newsletter follow. We welcome any and all comments.

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Health Minister Murray Elston tabled the Thomson Committee Report in the Ontario Legislature on December 17, 1985. The Thomson Committee received more than one thousand submissions and examined the cases of about two hundred patients (producing) a three hundred page report with thirty recommendations. Among its conclusions and recommendations are that:

> *research should be undertaken to define environmental sensitivity, establish criteria for diagnosis, assess

current treatment, and determine what assistance is needed by people who attribute their ill health to the disorder;

*a publicly funded multidisciplinary environmental unit be established for three years to investigate the disorder;

*Social Assistance programs, in particular those under the Family Benefits Act, be reviewed to ensure that hypersensitivity patients are recognized as disabled;

*educational materials be developed for the public, physicians, and Public Health nurses, and

*the Ontario Medical Association consider establishing an Environmental Health Subsection.

Mr. Elston conceded in the Legislature that it is certain that many patients who attribute their ill health to the disorder suffer greatly and that some of them are seriously disabled.

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WINNIPEG FREE PRESS - December 18,1985
Toronto (CP) "Those afflicted with a mysterious malady which renders them hypersensitive to allergies, should be recognized as disabled and entitled to social assistance benefits, says a report prepared for the Ontario Health Ministry by an independent committee. The six member committee, headed by former provincial court judge George Thomson, was appointed in November 1984 to study environmental hypersensitivity, a condition not recognized by many medical authorities but described as multiple sensitivities or allergies to a wide range of food, chemicals and ordinary household and workplace substances. The committee said that patients "should not be deprived of minimal levels of support because of disagreement within the medical profession regarding the causes of their conditions" and urged that all basic social assistance programs - particularly family benefits - be offered to them. "There is no doubt in our minds that those who administer social assistance programs should be receptive to individual patients judged to be disabled while the precise cause of their disability is established." Health Minister Murray Elston, who tabled the report in the legislature, conceded that while there are many outstanding questions and no "clear-cut clinical picture" of the disease, "it is certain that many patients who attribute their ill health to the disorder suffer greatly and that some of them are seriously disabled." The committee also recommended, because of the respiratory difficulties encountered by sufferers of environmental hypersensitivity, that more stringent measures be taken to limit smoking in public places and it supported municipal bylaws cracking down on smokers."

[BRAVO, Ontario! Provinces east and west, friends and fellows south of the border, take note. It is a beginning ... WE EXIST!]

AND MORE GOOD NEWS

From the Waterloo-Wellington (formerly Kitchener) Branch News: (In Ottawa, in 1985) POLLUTION PROBE organized a week-long environmental festival on the theme "The Earth: Ours To Care For" with exhibits in the National Museum of Natural Sciences, representing the environmental concerns of such organizations as UNESCO, Parks Canada, Canada Research, Canadian Organic Growers and the Human Ecology Foundation of Canada. The highlight of the many events hosted was the ENVIRONMENTAL AWARDS CEREMONY which recognized and identified individuals whose work had a significant impact on the environment both nationally and internationally. DR. JOHN MACLENNAN of Dundas, Ontario, a pioneer in the field of human ecology and in the research and treatment of environmental illness was presented an award by Dr. David Brooks, President of FRIENDS OF THE EARTH. We are indeed proud of the recognition accorded Dr. Maclennan." [BRAVO!]

THE SECOND ANNUAL MEDICAL SYMPOSIUM ON THE EFFECTS OF THE ENVIRONMENT ON MAN IN HEALTH AND DISEASE, sponsored by The Canadian Society for Clinical Ecology and Environmental Medicine and The Human Ecology Foundation of Canada, will be held Friday and Saturday, April 4 & 5, 1986, at the Metro Toronto Convention Centre in Toronto, Ontario. Registration is open to M.D.'s ($200), other Health Care Professionals ($150), and Medical Students (special rate of $30). The conference is limited to 125 people, so register early. If you did not receive a brochure with your Quarterly, write or telephone for further information:

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WHAT TO DO IN AN ALLERGIC EMERGENCY

by Sharon Faelton and the Editors of Prevention Magazine

Reprinted from THE ALLERGY SELF-HELP BOOK (c) 1983 by Rodale Press, Inc. Permission granted by Rodale Press, Inc., Emmaus, PA, U.S.A. 18049. (Excerpted from Chapter 14, pages 228 to 232)

If you're like most allergic people, chances are good that you'll never have a life-threatening reaction. Even then, there's only one chance in a million that the reaction will be fatal - and those odds are less than that if you know how to handle it.

As with choking or heart failure, a severe allergic reaction calls for immediate first aid. The first 10 or 15 minutes are the most critical. (The very most you can hope for is an hour - then it might be too late.) But that "grace period" still doesn't give you much time to locate and reach a doctor. So it's imperative that you learn to recognize an allergic emergency and know exactly what to do about it.

KNOW THE WARNING SIGNALS

As the term implies, an allergic emergency is a reaction that can be fatal. The most common life-threatening reaction is anaphylaxis - an explosive bodywide response to an allergic encounter. The individual first becomes weak, pale, anxious, dizzy, has hoarseness or difficult breathing - then usually collapses. That may be followed by any of various symptoms, involving four major organ systems:

GASTROINTESTINAL TRACT: nausea, vomiting, stomach cramps, bloating and diarrhea;
SKIN: intense flushing, itching, hives and swelling (especially swelling at the site of an insect sting);
HEART AND BLOOD VESSELS: rapid heartbeat and low blood pressure (this is itself also known as anaphylactic shock);
RESPIRATORY TRACT: sudden runny nose, swollen vocal cords, uncontrollable coughing, wheezing, bronchospasm and constricted airways (caused by internal swelling).

The basis of all anaphylactic symptoms is an overwhelming surge of histamine and other allergy-provoking substances (for example, newly recognized leucotrienes) from mast cells and basophils, the allergen-sensitized tissues (discussed in Chapter 1, What Is An Allergy?).

Of those symptoms, however, the biggest threat to life is constricted airways, which can cause death within minutes if not opened. The second is low blood pressure, or shock.

Penicillin is the most common cause of anaphylaxis and accounts for about three out of four fatal reactions. It's followed by - in order of incidence - venomous insect stings, radiographic dye

(a diagnostic medium), aspirin and related drugs, and foods such as eggs, nuts or seafood.

Less common than anaphylaxis but equally threatening is laryngeal edema (swelling of the windpipe or throat). It may occur alone or as part of anaphylaxis. A severe, uncontrollable form of asthma called status asthmaticus is also considered an emergency. The symptoms of a serious asthma attack are:

-an attack that fails to improve or is increasing in severity after several hours, or that does not respond to routine drugs;
-wheezing that is first loud and then stops, accompanied by extremely labored and difficult breathing;
-fatigue and weakness;
-irregular heartbeat, or a pulse higher than 140 beats per minute (or higher than 160 in children under age six);
-obvious bulging of the neck muscles, expanded chest cage, sweating and noticeable deepening of the notch over the breastbone.

BE PREPARED - IT CAN SAVE YOUR LIFE

Emergency kits of allergy drugs, sold through pharmacies, are prescribed to people who have at any time experienced life-threatening reactions or who have a history of very severe symptoms. If you fall into either of those categories, you should own an allergy kit or an automatic-injectable adrenaline kit. One kit should carried in your handbag, briefcase or auto, and another should be kept at home. If you begin to react and have any reason to feel you're headed toward a severe, uncontrollable reaction, you should be prepared to take emergency action immediately.

Say you inadvertently eat nuts, to which you are extremely allergic, and you begin to feel very sick. The first order of business is to reverse all the alarming changes your body is going through. So the emergency kit contains a vial of adrenaline. That's the synthetic form of epinephrine, the hormone that plays a key role in keeping all body systems running on an even keel. A single shot of adrenaline pushes blood pressure back to normal and reduces swelling (which keeps your airways open and helps you breathe). It's the quickest and most effective way to neutralize a severe reaction. Adrenaline calls for medical directions; your physician should teach you how to give yourself an injection and supervise a practice shot. The procedure is easy to learn, since adrenaline is simply injected into the fatty tissues under the skin, and not into a hard-to-pinpoint muscle, vein or artery.

The adrenaline in your emergency kit should be checked out once a month to be sure the solution is not discolored or out-of-date, which would indicate a decrease in potency. The drug deteriorates in sunlight, so don't store the kit on the dashboard of your car or in front of a window.

Adrenaline is also available in an aerosol form, which you can inhale to restore normal breathing. Although not a substitute for injected adrenaline, the aerosol may help to relieve laryngeal edema or asthma more quickly. Test spray your aerosol adrenaline periodically to be sure that the valve opening is free of dust. If it's clogged, clean it with soapy water.

Kits are also usually equipped with antihistamine tablets to further counteract the flood of antihistamine that is to blame for much of an allergic reaction. Find out exactly how much antihistamine you should take, to save valuable time in an emergency. If you've been prescribed asthma medication, be prepared to take that, too. As much as we advocate nondrug means for day-to-day control of allergies, you shouldn't hesitate to use whatever first-aid measures are necessary in a life-threatening situation. The possible side effects of a single dose of these drugs is a minor concern compared with the certain consequences of not taking them.

Tourniquets are also included in many allergy first-aid kits. Applied near a sting, a tourniquet will slow the circulation and absorption of venom. The problem is that a tourniquet also stops the circulation of blood. While routine use of tourniquets is discouraged by most doctors, many allergists say that if a highly sensitive person is stung by an insect, the tourniquet is justified - IF it's applied immediately after the sting occurs and on an arm or a leg only. Even then, a tourniquet is merely a stopgap measure to block the spread of venom until a doctor can be reached.

If no tourniquet is available, you can make do with a strip of cloth, thick cord, belt, dog leash or other similar device. Tie the tourniquet two to four inches above the sting (toward the trunk of the body). Do not tie the tourniquet so tightly that the circulation is cut off. You should be able to slip your fingers under the band. And be sure to loosen the tourniquet every five minutes (American Medical Association Handbook of First Aid and Emergency Care, Random House, 1980).

If the sting was inflicted by an insect with a stinger, scrape the stinger out of the skin with your fingernail or a dull knife. Do not grasp or try to pull the stinger out - that would only squeeze more venom into the wound. (For more information on reactions to insect stings, see Chapter 6, What To Do About Insect Allergies.) Place a cold pack or ice wrapped in cloth on the sting area to reduce total swelling.

After taking these first-aid steps, you should call an ambulance or have someone drive you to the nearest hospital emergency room. There you will be given further medication and oxygen, if necessary, to bring the reaction under complete control.

During any severe allergic reaction, you should lie down on your side or with your head turned to the side to avoid choking if you become sick to your stomach. Even if you don't feel nauseated,

though, you'll be more comfortable if you can stretch out.

Obviously, there's always the possibility that you may not be able to take emergency action yourself. If you can't breathe or you pass out, someone will have to take you over. Your spouse or other family member should be as familiar as you are with the location and use of emergency medications. If you aren't breathing and no medication is on hand, the person with you should call for emergency aid and know how to give mouth-to-mouth resuscitation to open your airways.

The name and phone number of your physician should be posted near every phone in your home, along with the number of your ambulance service and the location of the nearest hospital.

Anyone with serious allergies should also wear a bracelet or tag or carry a drug information card identifying items to which the individual is allergic. This information will save precious time and prevent medical personnel from mistakenly treating you for other causes of collapse, such as stroke or heart failure. The identification tags are available from Medic Alert Foundation International, P.O. Box 1009, Turlock, CA 95380. (In Canada, the address is 170 St. George Street, Suite 419, Toronto, Ontario, M5R 2N1, telephone (416) 923-2451.)

There are those rare occasions, of course, when an individual reacts to an allergy shot received in a doctor's office as part of routine therapy. For that reason, your doctor probably won't send you merrily on your way as soon as you've had your injection. No one should be left unattended for the first 30 minutes, at the very least, after having an allergy shot. Some doctors, in fact, prefer to play it safe and keep you an hour. And any doctor giving allergy shots should be prepared to give adrenaline, open an airway and if necessary give oxygen to a person who unexpectedly reacts in the office. You shouldn't hesitate to ask if your doctor has all the necessary medication and equipment on hand. That's especially true if your pediatrician, ear-nose-and-throat doctor or family physician customarily gives you your allergy injections. A caring doctor isn't likely to take offense at your concern. After all, physicians want to avoid trouble as much as you do.

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WHAT'S NEW IN RESEARCH? THE DISABLING DISEASES RECONSIDERED

PARKINSON'S DISEASE: AN ENVIRONMENTAL ILLNESS?

by Mary Merlin Nelson

As promised in the last edition, we're going to look at a disease of the central nervous system first described by James Parkinson in 1817 as PARALYSIS AGITANS, or 'shaking palsy'. A prevalent, serious neurological disease (after strokes, the most common affliction of the nervous system), the illness was thought to be a disease of the elderly. New research shows differently.

Acute carbon monoxide poisoning, chronic exposure to heavy metals such as mercury, lead or manganese, carbon disulfide, cyanide, methylchloride and some photographic dyes have been reported to produce some or all of the symptoms of parkinsonism. Recently, a drug researcher showed a videotape to a conference audience. Parkinson's syndrome had suddenly struck a 36-year-old heroin addict, ending his productive life. To see a videotape of George is to watch his pathetic destruction by a deadly toxin. The poison, which attacked his brainstem in a matter of moments, came from MPTP, a so-called "designer drug" or slightly altered molecular copycat of an opiate such as heroin, cocaine, demerol, etc.; a neurotoxin, or nerve poison, which can cause Parkinson's symptoms in some users up to two years after they inject it.

Parkinson-like disorders are a fairly common group of symptoms adversely effecting approximately 15% of all patients who use tranquilizers (notably phenothiazines) for an extended period of time, regardless of their age. Drugs that produce parkinsonism have in common the capacity to prevent the action of DOPAMINE in the BASAL GANGLIA, which form an essential segment of the EXTRAPYRAMIDAL MOTOR SYSTEM, complementing the function of the pyramidal (voluntary) motor system. Damage to the extrapyramidal system results in inhibition of voluntary movements.

Most of the clinical features of Parkinson's fall into three general categories: bradykinesia, tremor and rigidity. The slowing down of voluntary actions (with apparent difficulty in initiating movement) is often so severe as to cause the patient to "freeze" into immobility. Early parkinsonism is easily misdiagnosed. A face that goes from smiling and friendly, to emotionless and depressed with a slight bulging of the eyes and a barely noticeable tremor. It looks suspiciously like anxiety, nervousness or depression. Off to a psychiatrist for treatment with phenothiazines or tricyclic antidepressants? Weakness and stiffness of one hand, stiff joints and difficulty in getting out of bed, or up from a chair. Early stroke symptoms? Arthritis? A prescription for painkillers? Muscle relaxing tranquilizers?

Impairment of intellectual capacity and dementia are found in some patients. Symptoms progress, slow but sure, spreading from one area to another with the upper part of the body affected first, and the shuffling gait and lower body symptoms coming after. Synthetic anticholinergic drugs are used (cholinergic

pertains to nerve fibers that release acetylcholine). Among their side effects are blurred vision, mild confusion, dry mouth and drowsiness. In toxic doses, anticholinergics produce agitation, hallucinations and body temperature elevation. By changing the balance of ACh (excitatory) transmissions, they interfere with the balance of dopamine (inhibitory) transmissions in nerve cells. The rigidity of Parkinson's disease is known to result from excess impulses transmitted in the cortico-spinal system.

PARKINSONISM IS A SYNDROME OF DOPAMINE DEFICIENCY. About 80% of the dopamine in the human brain is concentrated in the basal ganglia (the nuclei which code and relay information associated with the control of muscle movements) and dopamine is the neurotransmitter that activates the receptors. In parkinsonism, there is a marked deficiency (10% or less of normal). The dopamine receptors on the basal ganglia nerve cells are normal; it is the quantity of the transmitter that is deficient, and so L-Dopa (levodopa, which is a precursor of dopamine) is given to patients. In most patients, levodopa partially relieves the changes of mood that are characteristic of Parkinson's disease, as well as bringing about an improvement in overall functional ability and improving such disturbances as speech, handwriting, swallowing, respiration, posture and gait. There is a general alerting and improvement in mental function, and an increased vigor and interest in self, surroundings and family as a benefit of therapy with levodopa, but a significant number of patients develop serious behavioural side effects. For that and other reasons, some neurologists reserve it for severe parkinsonism, and begin treatment for mild parkinsonism with anticholinergic agents. Certain ANTIHISTAMINES, including diphenhydramine, are also used in the treatment of Parkinson's disease.

A researcher and professor of neurology at the University of Saskatchewan, Dr. Ali Rajput, believes something in that province's water (a shortage of magnesium or calcium?) could be a factor in the illness that hits about one in 500 people in rural Saskatchewan. Lecturing in Winnipeg in January of 1985, he said his research team had recently discovered that the levels of magnesium in the brain cells of Parkinson's disease patients were significantly lower than the levels ordinarily found. Dr. Rajput is one of several researchers who now believe in an environmental cause for this nervous system disease.

Is Saskatchewan's water a clue to Parkinson's, and if so, why? Dr. Rajput's study group consisted of 18 patients who had started showing symptoms at the relatively early age of about 40, and the one thing they had in common was drinking water that was drawn from the ground in the Saskatchewan farms and communities where they had grown up. Shortages of magnesium and calcium in soils have been linked to Parkinson's disease in New Guinea as well. Studies of chemicals in the water are currently being undertaken.

WHAT IS THE ROLE OF CALCIUM AND MAGNESIUM?
Calcium is essential for the proper functioning of nerve and muscle. Lack of calcium results in osteoporosis (bone

softening), possibly accompanied by low back pain, muscle spasms, and a tendency of spontaneous fractures of bones. It plays a role in both coupling excitation with muscle contractions, and in the release of chemical transmitters such as ACh and dopamine. The skeleton contains more than 90% of the body's calcium. Symptoms of lack of magnesium include spasms of the wrists or ankles, involuntary movements, muscle tremors, delerium or convulsions. The effects of magnesium on the central nervous system (CNS) are similar to those of calcium. Hypomagnesia causes increased CNS irritability, psychotic behaviour, disorientation and convulsions. Magnesium has a depressant effect on skeletal muscle, and excess magnesium causes a decrease in ACh release by motor nerve impulses.

One of the classical symptoms of Parkinson's is bradykinesia (a symptom familiar to many ecologically ill patients): a slowness of voluntary muscle movement. The patient begins to have trouble doing things that take fine movements, such as tying shoelaces, sewing, writing, shaving. Muscle movements in the face slow. Sometimes it's difficult to swallow, or speech may become monotonous. Arms and legs don't work right. One leg might drag, or the patient will take short, shuffling steps, stooped over. Because the muscles of the body slow in their responses, even getting up from a chair becomes difficult. Rigidity or stiffness of muscles; muscles that become tight and make passive movement more difficult, and other associated symptoms that may include dry flaky skin, excessive sweating and seborrhea, depression, trouble reading, learning disabilities, and arthritis-like symptoms make the diagnosis of chemically induced parkinsonism and/or Parkinson's syndrome extremely difficult.

Let's take another look at a known parkinsonism-chemical link. Phenothiazines are used as anti-psychotic tranquilizers, antihistamines (allergy pills), antinausea pills, antiemetics (to control vomiting), ointments (Phenergan antihistamine cream), and even in a liquid prescribed to ease the pain and discomfort of teething in infant children. Veterinarians used them as a vermifuge to rid their animal patients of worms. Psychiatrists use them for the restoration of emotional calm and relief of severe anxiety, agitation, and psychotic behaviour. The drug's location of action is those nerve pathways in the brain that utilize the chemical dopamine for the transmission of nerve impulses. The present theory is that phenothiazines act to correct an imbalance of nerve impulse transmissions that are thought to be responsible for certain mental disorders. When phenothiazines are prescribed, the complete avoidance of excess heat and insecticides is urged by considerate pharmacists. Is it a coincidence that in the 1950's phenothiazines were merely "greenish granules or flakes, C12H9NS: used as an insecticide and vermifuge" (Dorland's Pocket Medical Dictionary, c. 1959)? IS there a parkinsonism-pesticide link?

As we've already discovered, symptoms appear to be caused (in part at least) by an imbalance between concentrations of dopamine and ACh, two neurotransmitters we learned about in the March

1985 edition of the Quarterly (KNOW YOUR BODY). ACh is the transmitter for only a few pathways in the brain and spinal cord, but it is an important synaptic transmitter (released by parasympathetic nerve fibers) in the autonomic nervous system, and is the transmitter at the junction between motor nerve terminals and skeletal muscle cells. In that same edition (INDUSTRIAL PRODUCTS), we learned about the effects of certain pesticides (organophosphates) on the body and brain. Pesticides trigger toxic chemical interference with ACh. This interference causes nerve impulse transmissions in the body to become uncontrollable because of the buildup of acetylcholine at the ends of the nerve fibers.

Remember George? Several dozen drug users began showing Parkinson's symptoms after using a synthetic heroin street drug contaminated with MPTP, a chemical compound found in many types of pesticides and weed killers. Researchers have noticed the similarity between the effects of MPTP and industrial chemicals in the same family called pyridine compounds, that are extracted from coal tar and made commercially for producing herbicides, fungicides and insect repellants. The drug users were young, but their symptoms were indistinguishable from those of Parkinson's patients whose disease had begun in old age with a degeneration of cells in the middle of the brain. Researchers have since found that MPTP is transformed (in the brain) into a compound that prevents respiration (taking in of oxygen and giving off of carbon dioxide) of cells, thus killing them.

University of B.C. medical researchers have also found reason to believe that Parkinson's may be caused by environmental toxins. Parkinson's now afflicts 5,000 British Columbians and strikes one in 100 people in the over-50 population. Important new research is being done on patients in their 30's and 40's. The research team studied six patients from California who had been exposed to MPTP. The six had no symptoms of Parkinson's, but a process of injecting small amounts of Dopa tagged with radioactive isotopes and taking pictures of the brain with PET scanners, showed the patients had brain damage half-way between normal and that of Parkinson's. For the first time, the progress of Parkinson's disease can be watched in living subjects due to this tragically clear chemical link that continues to provide information about the unique, interacting functions of the nervous system.

In Quebec, farm families and people living near industry were studied by Dr. Andre Barbeau, head of neurology at the Clinical Research Institute in Montreal. His studies contend there is a direct relationship between environmental chemical exposure and a higher incidence of Parkinson's, and show strong evidence that toxins in pesticides are a key factor in the disease's development. In a study of 5,000 patients, Dr. Barbeau found a Parkinson's rate of 0.89 per thousand residents in farming regions and near petrochemical plants and pulp mills that use fungicides, as opposed to a rate of 0.13 per thousand in areas and communities where pesticide use was low.

Dr. Barbeau's research also suggests some people are more genetically susceptible to Parkinson's because their bodies are less capable of eliminating the chemicals from their systems. A majority of the Quebec patients were found to have a genetic deficiency in their livers, and further, that an enzyme which normally inactivates chemicals in the body is missing in 67% of Parkinson's patients, and only 18% of the nondiseased population.

In the Physiology Notes at the beginning of An Introduction To Organophosphate Pesticides (March 1985, Vol. VII, No. 1) H.E.F. members learned about acetylcholinesterase (AChE), an enzyme that breaks down ACh, and about chemicals that inhibit AChE, called anticholinesterase agents. Organophosphates are only one class of pesticides known to be anticholinesterase agents. They are further classified as irreversible in their effects on the nervous system. Carbamate pesticides are considered reversible, but they are also anticholinesterases. They disrupt the process of acetylcholine (and thereby, dopamine) in insects AND IN MAN, and are known to cause hypersensitivity, chemical allergy, birth defects, and a Pandora's Box of other problems.

Too often, the argument that "organic industrial chemicals" and other toxins are "merely man-made copies" of chemicals that occur naturally in our bodies, is used against us. If one stops to consider the delicate balance our body must keep in its neuro-transmitting chemicals; the increasing incidence of ecological illness and environmental hypersensitivity; the latest research on illnesses such as Parkinson's disease; the long-term effects of chemicals like DDT, PCB and dioxin, formaldehyde, and hundreds of others that came to light too late; s/he will surely realize we are interfering with the systems that make our bodies function on a day-to-day basis. Deliberately or accidentally, we are changing our genetic structures, altering the balances of chemical messengers within our bodies by exposing them to toxic chemicals at work and at home, crippling children in our wombs, poisoning our species. Extinction is forever.

There is a current hypothesis that schizophrenia is due to excessive activity of dopamine-mediated synapses (gaps between cells where nerve impulses are transmitted one to the other), especially in the limbic system (including the basal ganglia). See PHENOTHIAZINE DRUGS: FRIEND OR FOE? beginning on page 39.

THE PURPOSE OF A (CHEMICAL) DRUG IS TO ALTER THE BALANCE BETWEEN ONE NEUROTRANSMITTER AND ANOTHER, TO STOP OR START OR ALTER ONE FUNCTION OR ANOTHER, BY CHANGING THE BODY'S OWN CHEMICALS WITH SYNTHETIC MIMICS OF THEM. IT'S AS SIMPLE AND AS COMPLICATED AS THAT. To work effectively in their role as a "fine-tuning" mechanism, dopamine and ACh must be in perfect balance. Alter the balance, and you change the body's functions.

Parkinson's disease is only one example of the disabling nervous system illnesses that share similar symptoms with those of multiple sclerosis, environmental hypersensitivity, psychosis and schizophrenia with their chemical therapies, and too many other

manifestations of maladjustment to our environment, including pesticide poisoning. Day after day, new articles linking environmental chemicals with the illnesses of humankind in industrial countries appear in our North American newspapers and magazines. Perhaps it's time we paid closer attention to what's being written. What's new in research? Toxicology courses (now being studied, reviewed and undertaken in our universities by students of chemistry and pharmacy, but too often not by medical students) should be "required reading" for physicians and for US, you and me. We owe it to ourselves to be informed. Let us all remember Bhopal. Only the scale of the accident is different from what happens in North America day by day by day.

Environmental illness is on the increase, and it has many faces. Is there a connection between parkinsonism and environmental hypersensitivity? Between chemical allergy and nervous system malfunction? Between environmental illness and industrial chemicals? Our survival depends on our increasing search for knowledge, and the wisdom to act on it before it's too late.

RESEARCH: Goodman & Gilman's 'The Pharmacological Basis of Therapeutics; Guyton: 'Textbook of Medical Physiology'; Vander-Sherman-Luciano's 'Human Physiology - Mechanisms of Body Function' and Herfindal-Hischman 'Clinical Pharmacy 3rd edition'.

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IN OTHER RESEARCH NEWS

UP TO DATE DATA ON PESTICIDES CALLED LACKING (Winnipeg Free Press 16 Jan 1986): Of the 500 pesticides used in Canada, 80% were registered before 1980, and their safety tests were done before modern standards were imposed to ensure they don't endanger people or the environment. "People are very concerned about (chemical) residues in the food they eat. They don't seem to make the connection between their food supply and the pesticides" said Janet Taylor, the associate director of pesticides for Agriculture Canada. Environmentalists, universities, farm labourer organizations and the general public have placed pressure on the government to take a hard stand on pesticides used in food production. When a U.S. laboratory that conducted tests for several international chemical companies was found to have falsified test results in the late 1970s [see EILR excerpts, HEF Quarterly March 1985, INDUSTRIAL BIOTEST CONVICTIONS. Remember "IBT chemicals"], the public outcry in Canada was unmatched in the world. Consumers wanted the 100 chemicals affected in Canada deregistered until proper data was prepared, but "that would have left agriculture and forestry in a very difficult situation". The chemicals remain in use (and available), but under more "stringent regulations regarding their use". Ms. Taylor was quoted as saying "I think Canadians are one of the most aware populations in the world when it comes to pesticides."

* * * *

FOOD ALLERGY-MIGRAINE THEORY GETS BOOST (Toronto Globe and Mail, 14 Jan 1986): New research is lending credence to a long debated idea that food allergies may cause migraines. Several studies done in the United States and England in the past five years have shown about 75% of migraine patients are allergic to five or more foods, while some are allergic to 20 or more. Researchers involved in the recent studies say physicians who treat migraines should keep an open mind. "Those who are skeptical have not adequately investigated the role of food. It is a time consuming process, and the tests are sometimes faulty and difficult to do. But the tools we use are showing us there is a much higher incidence of food allergies than previously believed", said Dr. James Breneman, chairman of the food allergy committee of the American College of Allergy for 15 years. Dr. Breneman said migraine patients tend to be allergic to common foods they eat every day. These foods elicit a slow allergic response. Substances formed by the immune system in reaction to the foods are not manifest in blood vessels and other tissues until two or three days after the foods are eaten. [EUREKA! WE EXIST!]

WHAT'S NEW IN BOOKS?

THE MANDELLS' IT'S NOT YOUR FAULT YOU'RE FAT DIET
by Marshall Mandell, M.D., and Fran Gare Mandell, M.S.
Harper & Row Publishers, New York

reviewed by Toronto Branch member Lydia Gingell

The book deals with food allergy addiction and how it can turn you into a compulsive eater or how you can develop water retention with food allergy and not be aware of it, but I feel its main usefulness is the fact that it gives a rotary diversified diet in an easy to follow format. For each day of 21 days, the 10 foods are listed, and then recipes are provided. Foods are readily available at fruit stores, bulk food stores or supermarkets. I only had one item for the first three days that I had to get in a health food store.

It was hard for me to consider doing something like this because it seemed bewildering, but they made it very methodical and easy to follow. All the thinking is done for you. Food Family Charts are included, as well as Common Sources of Hidden Food Allergens.

Great stuff, but CAUTION withdrawal during the first four days can be utter hell! [Thanks for sharing, Lydia.]

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A BIG PART OF WHAT YOU SEE DEPENDS ON WHAT YOU'RE LOOKING FOR
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DETOX: ESCAPING YOUR CHEMICAL CAPTORS

Excerpted from DETOX by Phyllis Saifer, M.D., M.P.H. and Merla Zellerbach

THE TOXIC REACTION

Doctors are often amazed at the number of people who tolerate or ignore mildly unpleasant symptoms. These individuals think that everyone is drowsy after meals, wakes up with a slight headache, or feels claustrophobic around smokers. Because their suffering is neither severe nor disabling, they shrug off minor ailments as too insignificant to treat. Afraid of being called complainers or hypochondriacs, they make little or no effort to seek treatment for or to determine the source of their symptoms. The result is a large population of semihealthy citizens suffering a variety of avoidable illnesses from a myriad of avoidable causes.

These causes may be attributed to one or more of the various toxins - substances that chemically react in the body and produce damage - abounding in the environment. Our bodies recognize these enemies and send us distress signals in the form of headaches, rashes, nausea, chronic fatigue, joint aches, and other symptoms. Inner alarms may seem insignificant in our busy lives, but they signify a "breakdown" in the body and should not be ignored - particularly when there is an effective means of alleviating them.

The concept of self-purification was part of a religious cult dogma two decades ago; today, it is medically validated and publicly accepted. This acceptance is due in part to media coverage, which regularly features stories of widespread toxic contamination. Barely a day passes without news of another polluted river, chemical spill, or abandoned dump site leaching poisons into our air and water. These incidents are newsworthy, inspiring great waves of emotion and controversy. What is not widely publicized is our steady exposure to tens of thousands of toxic substances we may never have considered as injurious.

Recent scientific research has shown that both natural and synthetic chemicals directly affect our well-being; for instance, many "hopeless" mental disorders such as depression and schizophrenia have been magically "cured" by the simple removal of a food or one of its ingredients. "Untreatable" rashes suddenly disappear when the sufferer stops taking aspirin, moves to a different area, or changes hairdressers and escapes a toxic spray or shampoo.

Hearing about or experiencing the effects of toxic exposure make us "bodywise" - concerned about what we take into our systems in the form of food, air, and chemicals. Citizens of the 1980's know more about health and environmental toxins than any previous generation. Each individual wants a body that is free of irritants and poisons, and assurance it will stay that way.

This assurance is nearly guaranteed as medical and scientific advances make it possible to "detox" - that is, reverse many common manifestations of toxicity. The procedure entails reducing or eliminating the toxins; unless the damage is too advanced to be reversed, your health will greatly improve. The picture painted of us as victims of continual toxic assault need not be a true one. We are far from helpless. We have the means to control this aspect of our lives.

ADDICTION AND WITHDRAWAL: HOW TO KNOW IF YOU ARE ADDICTED

The greatest hurdle most people face when detoxing from habit-forming substances is going through withdrawal - with its variety of physiological and emotional symptoms - unscathed. DETOX guidelines will prepare you physiologically for those difficult moments when your body's chemistry is aching for the burst of energy from a cup of coffee or the calming effects of a tranquilizer.

You may not think you are addicted - few people do. If, however, under normal circumstances, you cannot control when you start or stop an activity, consider yourself addicted. Let us look at three people who claimed they could easily break their habits.

CASE 1. Gary B. had frosted corn flakes for breakfast every morning, drank sugar-drenched Sanka on his coffee break, lunched on peanut butter, jelly, and whole wheat bread, snacked on candied fruit bars, washed down dinner with sweetened herbal tea, and topped the meal with carrot cake. Despite taking a variety of vitamin pills and shopping at health food stores, Gary felt anything but healthy, with constant anxiety and irritability, and frequent headaches. By the time he was forced to admit to himself that he was a sugar junkie, Gary was into his second year of addiction.

Working as a customs officer often involved physical exertion; Gary feared he would not get through the day without the energy he got from sugar. He decided to start kicking his habit by cutting down rather than cutting out. First to go were the between-meal snacks; his Sanka tasted fine with saccharin, and while fresh fruit was less satisfying, it was at least a filling replacement for the candy bars.

Then he decided to eliminate all sugar from his diet at once, replacing it with nuts, seeds, and fruits, and aiding the detox process with large quantities of water. He felt some discomfort for three days and suffered occasional dizzy spells, blurred vision, and periods of depression. He had little energy for work, but his boss would hardly understand if he took time off to "withdraw from candy bars."

On the fourth day, his depression cleared, his mind seemed strangely sharp, his palate had recovered its blunted sensitivity and the natural flavors of food almost overwhelmed his taste buds. Gradually his physical energy returned, and with it, a

sense of self-mastery and control. Now he is an ex-sugar junkie and proud of it. Life is so much sweeter.

CASE 2. Patsy F., a social worker, smoked three packs of cigarettes a day. Though her husband and children nagged her to quit, she knew that she was not addicted and could stop at any time with no problems.

Patsy always bought cigarettes at the office vending machine. One day the price was hiked, and she asked a co-worker to lend her the extra quarter. The woman did so, growling, "You'll pay anything to poison your lungs!"

"Her remark hit me," said Patsy. "If cigarettes had cost $25 a pack, I would have paid it. When I realized how far gone I was, I turned and walked away from the machine. It was murder that first week; I had a headache that wouldn't quit, stomach cramps, and muscle aches. I wasn't sure I'd come out of the depression, but I did - and I haven't had a puff since then."

CASE 3. Mara D., a young fashion model, used a variety of cosmetics, but only one kind of hair spray: Red Rose. It kept her locks in place, scented the air, and gave her a psychological lift. Unknown to her, the toxins stimulated her central nervous system and supplied the physiological lift as well. Mara bought Red Rose from the druggist in case lots, always carried a can in her purse, and used it four and five times a day.

After many months, a constant runny nose and physical exhaustion led her to Dr. Saifer, who sniffed her aura of roses and became suspicious. Mara's strong denial of a possible link between her symptoms and her hair spray led her to see an old-fashioned physician who prescribed antihistamines, tranquilizers, and a vacation. When nothing helped, she decided to try a day without Red Rose - and felt so miserable, she finally began to realize her chemical dependency.

Returning to Dr. Saifer, she took the physician's advice to discard the Red Rose and restyle her hair into a casual bob that stayed in place by itself. After a week of irritability, frustration, and aching muscles, her nose stopped running, her fatigue disappeared, and her good spirits and youthful energy came bouncing back.

The fact that all three people were able to effect their own withdrawals without drugs or hospitalization does not mean that they were not hooked. Dr. Stanton Peele, psychologist and author of several books on addiction, interviewed subjects for more than ten years and found "intriguing evidence ... that people who break bad habits do best if they do it themselves. Heroin addicts often quit on their own. Alcoholics frequently don't need to dry out in a hospital but just go on the wagon with no particular anguish. Practically every cigarette smoker stops at some point - for anywhere from a few days to years."

Look around you. Are there chemical substances you eat, drink, wear, inhale, or spread on your skin that would be very difficult to part with? Can you give up any or all of them without anguish? Is there one you would cling to over all the others? If you have tried doing without the substance before and found it impossible, then you are addicted.

A more drastic means of finding out if you are addicted is to cease doing whatever you are doing. (Check first with your doctor when you have been using the substance for more than a year.) When you eliminate the habit, watch for possible symptoms which may occur hours or up to a week after your last contact with the offending substance, that may indicate the beginning pangs of withdrawal.

Withdrawal symptoms can range in intensity and severity from mild anxiety and irritability to blackouts and seizures, although these latter are rare. Successfully coping with withdrawal and breaking your habit depends on:

1. Age and general health. Younger people usually have "newer" habits and more resilience. A healthy body offers more physical resources to draw on.

2. Mental state and psychological stress load. A positive attitude and freedom from tension are prerequisites to any successful withdrawal.

3. The length of time addicted. The shorter the addiction, the easier it is to break.

4. The nature of the substance, be it bubble bath or barbituates. Most people find caffeine less addictive than cocaine, and so on.

5. The dosage or concentration of the substance; if medication, the spacing of dosages and route of administration. Pills and tablets provide a problem because they are so handy and so easy to swallow.

6. The availability and extent of medical care, support groups, and family assistance, if needed. Human aid is never more than a phone call away.

7. Whether the addiction is private, or part of a subculture involving peer group pressure to continue use. So called "friends" often contribute to the problem.

8. Personal habits, including use of other drugs or toxic substances. Reduce the amount of synthetic chemicals in your life to hasten your recovery.

CAFFEINE: Marilyn B., an advertising executive, was drinking twelve to fourteen cups of coffee a day when she went to her doctor for a physical, complaining of "raw nerves" and frequent

anxiety attacks. Neglecting to take a diet history, the doctor prescribed the tranquilizer Librium and psychotherapy.

Fortunately, Marilyn's boyfriend was a health enthusiast with a passionate hatred for all drugs. He suspected the problem was caffeine addiction and begged her first to try tapering off. She did so, experiencing some flushing and sweating and a mild headache the first week, but with no symptoms at all the second week, when she switched to a decaffeinated brand.

Two weeks from the day Marilyn started cutting her caffeine intake, her anxiety disappeared, her nerves "healed", and she reported "a most amazing rejuvenation." Coffee still sits on the kitchen shelf for guests, but taped to the can is a poignant reminder: the unfilled prescription for Librium.

In moderate doses, caffeine probably does no more harm than the sugared coffee, soft drinks, regular tea, chocolate, pain relievers, "water pills" and diet aids that contain it. The moment your intake begins to bring on such symptoms as craving, jumpiness, insomnia, headaches, anxiety, and irritability, you have reached the danger level. You are taking too much.

CHEMICALS: Dr. Theron Randolph of Chicago was one of the first medical practitioners to observe that some of his patients with chemical sensitivities tended to seek out the very substances that were harming them. They had even come to depend on continued exposure to keep their bodies in an altered state of homeostasis or body balance. Once the substances were removed, the metabolic functions readjusted in such ways as to cause both mild and severe temporary withdrawal symptoms.

The printer who carries fresh samples of his work wherever he goes, the beautician who feels terrible on weekends, and the artist who is compelled to go to his studio seven days a week may all be as hooked on chemicals as a compulsive glue sniffer. The printer is addicted to ink fumes, the hairstylist has to inhale scents and sprays, and the artist must have his quota of paint solvents in order to maintain a feeling of well-being, otherwise, all three will experience withdrawal.

George J. worked for a commercial exterminator, and although he wore a cotton mask to spray insecticide, he had never been too careful about his hands, hair, or clothes. Over the years he noticed that he felt more and more sluggish in the early morning and on days when he only did paperwork. The moment he grabbed his overalls, spray gun, and other supplies his energy level jumped. The pattern became so predictable, and he felt so poorly between exterminations, he suspected that something abnormal was happening in his body.

A friend sent George to see Dr. Saifer, who tested him and found a marked sensitivity to kerosene, a common petroleum distillate used in insecticide sprays. When George learned that he was addicted, he decided to go to an outpatient detox center. He

suffered dizziness, muscle cramps, and a headache for the first two days. On day three, he reported a gassy taste in his mouth, a strong kerosene odor about his body, and an intense flashback, in which he re-experienced a long-forgotten illness. Afterward, he slept for twelve hours.

The headaches cleared on the fifth day, and by week's end, all his symptoms had disappeared. He felt shaky but encouraged, and gradually regained his strength at home. Luckily, he was able to change chores at work, so that he no longer had to spray insecticide.

FOOD: Waking up was a gloomy experience for Camilla P., yet the world would brighten considerably after her morning toast and coffee. Without knowing it, Camilla was hooked on wheat. Her sensitivity to this food caused her to depend on it to keep her metabolism in its altered state. When the wheat was removed, the metabolic functions previously acting at a certain level had to be readjusted, causing the sensations of withdrawal.

In her office at the bank, Camilla would usually eat a diet lunch of fruit and cottage cheese. By mid-afternoon, she would feel unaccountably depressed, grouchy, and angry - the beginning of withdrawal symptoms. Two cookies gave her a quick fix and picked her up. Rolls at dinner fulfilled the same function; so did crackers at bedtime.

A steady weight gain led Camilla to see Dr. Saifer, who noted her dependence on bakery products and suggested a four day elimination diet, consisting mostly of foods she rarely ate. Camilla underwent forty-eight unpleasant hours of jittery nerves, stomach cramps, and urinary frequency. By the third day, her once bloated body was eight pounds lighter, water retention having been part of her altered metabolism. Her head was clear, and she felt no urge to attack the cookie jar. After six months of abstention, Camilla found she could eat small amounts of wheat every four days and not suffer reaction.

Learn to recognize the signs of food-sensitivity addiction. Some people are simply voracious eaters; they gorge themselves regularly on pasta, pizza, and pastry because they like the taste. When denied food, they may be frustrated or unhappy, but they are not physically addicted and will not suffer symptoms. Most likely they will feel less bloated, more energetic, and physically healthier if they cut down their food consumption.

The reverse is true of those with a food-sensitivity. When their particular food - be it wheat, corn, eggs, beef, or whatever - is unavailable, they become physically and mentally ill.

Answering yes to any of the following indicates that you may have a food addiction:

Do you often find it impossible to resist eating a certain food?

Do you ever feel desperate - that you would go anywhere or pay any price for that food?

Do you feel extremely weak, irritable, and anxious until you satisfy your craving?

Do you feel animated and energetic when you eat the food?

Food addiction leads to a repeated cycle of getting a fix, experiencing the first pangs of withdrawal, then taking another fix. If no fix is available, you may experience such symptoms as chills and trembling, sweating, anxiety, confusion, headaches, itching and even vomiting and diarrhea, much like a heroin addict's experience of withdrawing cold turkey. Some foods, such as milk and wheat, contain opioids - morphine-like substances - and are therefore more likely to be addictants.

In the words of Dr. Theron Randolph, "A person who demands his meals or drinks on time in order to avoid becoming sick or generally miserable ... gives himself away as a probable food addict."

FOOD SENSITIVITY DETOX PROCEDURE

1. Determine what is (or are) the food offender(s). Do this by challenge testing yourself. The procedure involves eliminating each suspected food one at a time, then reintroducing it to be certain it is a culprit.

2. Stop eating the offending food or foods and all products that contain them. Ask your doctor for a special diet for two to four days while your body adjusts to its newly nontoxic state.

3. If your doctor is a disbeliever in food addictions, you may want to consult a clinical ecologist who understands the problem and will offer psychological support through a possibly uncomfortable withdrawal. The worst of your symptoms should abate within forty-eight hours.

4. Institute the rotation diet (described in Chapter 4) and make this a permanent way of eating.

* *
EDITOR'S NOTE: Our thanks to Merla Zellerbach and Dr. Phyllis Saifer for granting us permission to reprint excerpts from DETOX: "a successful and supportive program for freeing your body from the physical and psychological effects of chemical pollutants, junk food additives, sugar, nicotine, drugs, alcohol, caffeine, prescription and nonprescription medication, and other environmental toxins". DETOX is published by Jeremy P. Tarcher, Inc., 9100 Sunset Blvd., Los Angeles, CA 90069. From your very first suspicion to a "clean system" ... RECOMMENDED READING. We hope to print future excerpts. Many thanks, Neighbours!
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S O M E T H I N G T O T H I N K A B O U T

* *

"Symptoms of the allergic toxemia syndrome such as fatigue, difficulty in concentration, or musculoskeletal complaints suggest looking more closely for environmental factors in the patient's problems. Some adult patients who present with psychological or systemic symptoms may also give a history of having 'outgrown' childhood allergies with symptoms such as hives, rhinitis, or asthma. Physical findings are rarely unique to environmental illness, although signs such as facial pallor, enlarged cervical lymph nodes, and 'allergic shiners' - dark, purple, edematous tissue below the eyes, without evidence of infection - are a common aspect of environmental illness, especially in children." DR. IRIS R. BELL, M.D. Ph.D.

(Quotation from 'CLINICAL ECOLOGY A New Medical Approach To Environmental Illness' published by The Commonweal Research Institute (c) 1982). Watch the June 1986 Quarterly for more from Dr. Bell, a physician and scientist whose research interests include clinical ecology and psychoneuroimmunology. Be informed.

* *

ECOLOGICAL TIPS FROM THE GREAT WHITE NORTH: Don't put your car keys in your mouth in winter if your spouse uses WD-40 to keep the locks unfrozen. [Thanks, Dr. Blair]

CAUTION URGED IN EXCESSIVE USE OF INSECT REPELLENTS: prolonged or excessive use of high-concentration insect repellents should be avoided because they can cause allergic and toxic reactions, The Medical Letter (a newsletter covering the pharmaceutical industry) reports. Diethyltoluamide, known as "deet" is absorbed through the skin. Even in low concentrations, it can cause hives and skin rashes. A woman went into anaphylactic shock after touching someone who had applied a 52% solution of "deet". An 8 year old girl developed a rash and altered behaviour after a few days' use of 15% "deet" and then had a grand mal seizure within hours of her first use of another repellent containing almost 100% "deet". The long term effects are still unknown.

[Washington Post, August 1985]

RESEARCHER CLOSE TO FINDING KEY TO CHILDHOOD SCHIZOPHRENIA: Dr. Sheila Cantor of the Schizophrenia Society of Manitoba said seven years of research into the disease point to a blockage of nerve impulse transmissions. Cantor said the nerves are separated by tiny gaps and nerve impulses travel from nerve to nerve via chemical messengers that jump the gaps. Her research indicates that in schizophrenic children the messenger is blocked from binding with the nerve endings. Schizophrenia is a disturbance in the part of the mind responsible for regulation of everything from walking to how much emotion one shows, Dr. Cantor said.

[Winnipeg Free Press, 6 January 1986]

E C O L O G I C A L I L L N E S S A N D T H E L A W

THE NEW CHEMICAL VICTIMS
by Earon S. Davis, J.D., M.P.H.

[Presented at the Toxic Torts Program of the annual meeting of the American Association of Law Libraries, July 9/85 in New York. Excerpted with permission from the ECOLOGICAL ILLNESS LAW REPORT]

Each of us views the potential health impacts of toxic chemicals from several different, often inconsistent, perspectives. As professionals, we provide information services to attorneys and others involved as either plaintiffs or defendants in chemically induced illness cases. However, as citizens of the twentieth century, we are also the custodians of our planet, with a moral commitment to protect our future generations. We are consumers who have grown accustomed to a standard of living partly achieved as a result of the chemical revolution which began after World War II. And yet, we are parents, grandparents, aunts and uncles who are concerned about the potential effects of toxic substances in our water, air, food, and soil. We are participants, and even investors in, a national and global economy that is seriously affected by our concerns over chemical safety.

To some extent, we are both the culprit and the victim in our toxic world. As wave after wave of chemical victims are identified, we are learning that we pay a very high price for "living better through chemistry". But it is not as simple as that. There are many thousands of individuals who have developed chemically induced illnesses as a result of wanton and reckless conduct by various companies and governmental units.

Increasingly, our common law tort system has been called upon to adjudicate the claims of alleged chemical victims. However, the courts are but one avenue for the chemical victims, with the bulk of our expenditures coming under our Social Security Disability system, the worker's compensation system, and private insurance carriers. In fact, the courts may be the least effective forum for adjudicating chemically induced illness cases. First of all, causation is often impossible to establish, since most chemicals do not cause unique diseases. While asbestos and some others leave "marker" tumors that almost never occur in the absence of that particular substance, the vast majority of illnesses can not be traced to one direct exposure to one specific substance. In fact, the vast majority of chemical victims will never even be identified. We have no way of knowing how many of those suffering from cancer, birth defects, infertility, and neuro-psychiatric disorders are actually chemical victims.

Most of us are aware of toxic tort, or mass tort, cases through the news media. Substances we have heard about tend to be ones where the victims are many, where they reside in close proximity or have effective national organizations, and where there are articulate spokespersons. These include urea formaldehyde foam insulation, DES, asbestos, black lung, DBCP, dioxin/agent orange,

brown lung, EDB, PCB's, TCE, TDI, and many others. I would like to run through a short list of substances that are suspected of causing a new generation of illnesses in individuals with whom I have been in contact:

* Formaldehyde in building materials as well as insulation.
* Pesticides and herbicides sprayed in and around homes.
* Carbon monoxide and other vehicle exhaust fumes from garages in high rise office and/or apartment buildings, and from faulty gas heating systems.
* Solvent fumes, including dry cleaning fumes.
* Involuntary tobacco smoking.
* Generalized indoor pollution caused by excessive weatherization of homes and office buildings.
* Plastic fumes due to fires.
* Diesel fumes and auto exhausts in the workplace.

The new category of illnesses to which I refer has been given several names; chemical sensitivities, total allergy syndrome, immune system dysregulation, chronic systemic poisoning, etc. I prefer to refer to them as "ecological illnesses", or E.I.

Briefly, E.I. appears to be the result of chemically induced immune system damage through which the individual becomes increasingly "sensitive" to different common substances in smaller and smaller amounts. For example, one individual's immune system may become so sensitive to formaldehyde that a whiff of new fabric or tobacco smoke (which also contains formaldehyde) could cause severe symptoms. The particular symptoms vary somewhat, but common ones include mental confusion, fatigue, headache, muscle and joint pains, and respiratory problems.

Once this illness has gotten out of control, an individual may require air filters and specially constructed "clean" living spaces, organic foods, purified water, and special household products in order to regain their health. Such individuals often cannot work in a modern office, since exposures to formaldehyde, pesticides, tobacco smoke, solvents, perfumes, and detergents - items to which we are each exposed daily - could cause serious health problems.

It is important to note that the medical community is not yet even convinced that this illness exists. While some physicians have been diagnosing and treating people with these illnesses for years, others still claim that they are largely emotional problems. One can only wonder why our Federal government and medical societies have failed to fund the research necessary to determine, once and for all, the extent and scope of ecological illnesses. Perhaps the overriding reason is that no one really wants to know. They don't want to learn how many people are being poisoned by their environments; they don't want to know how high a price we are paying for "better living through chemistry".

One can understand how difficult it is for the average toxic tort victim to function in our legal system. For the E.I. victim,

matters are even worse. Following are some of the additional problems faced by these chemical victims in pursuing their legal rights:

1. They are often too ill to go through the difficult process of finding an attorney competent in this highly specialized field. Illness also may hamper the exchange of information necessary for effective legal representation.
2. They have tremendous difficulty finding physicians trained in environmental and occupational medicine who are willing and/or able to make the diagnosis and to testify effectively on the causation issue.
3. Often, people (including physicians and attorneys) refuse to accept chemically induced illnesses, preferring to label the individual as emotionally disturbed, suffering from psychosomatic illness and/or hysteria. In fact, the stresses of being a chemical victim, as well as neuropsychiatric effects of many substances, often contribute to the appearance of a psychiatric disturbance.
4. They often are too ill to be examined and/or treated by the defendant's physicians, which is often difficult for a court to understand. I have been in touch with people who have been intentionally exposed to very hazardous chemicals by defense physicians in an effort to determine whether that person is really as "sensitive" as they claim. To others, specific tests and biopsies are sought which could cause very serious illness to an ecologically ill individual.
5. They are often too ill to attend hearings and depositions in normal settings or to travel any substantial distances. Often, the court is asked to order that any depositions be held in a "safe" room, often in the plaintiff's home.

CONCLUSION:
What does the future hold for these and other toxic chemical victims? Most certainly, recognition of ecological illness is increasing daily. Research is now being performed on the immunologic and neurologic effects of many substances. Attention to indoor pollution, food purity, and pesticide misuse is growing rapidly. However, the common law tort system must eventually give way to a larger victim compensation system. There are far too many people out there who are disabled due to toxic chemical exposures. And the class of chemically sensitive individuals is growing at an enormous rate. It is impossible to trace the illness of each individual to specific chemicals released by a specific manufacturer. Too many victims fall between the cracks of our legal system.

The tort system has been ineffective in creating incentives for better corporate decision-making. Our government regulators and corporations make innumerable decisions for us as to how much risk is acceptable for a given product or use. However, there is no effort to find the poor slob who happens to be that 1 in 100,000 who gets cancer from whatever makes plastic more flexible. Perhaps the public will accept risks like that, but fundamental justice requires that the individual who draws the

"short straw" be compensated. This is simply not the case at present. We must ask how many 1 in 100,000 chances are "reasonable" for us to assume.

Given the tens of thousands of chemicals in use, and leaving room for additive and synergistic effects, we may already have accepted more risk than the public would find tolerable. Of course, that does not address the fact that risk assessment is performed almost solely on cancer risks, forgetting risks of neurological problems, birth defects, emotional disturbances, infertility, etc. It is one thing to base estimates of carcinogenicity on tests performed on rats and mice. It is quite another thing to measure the nuances of mental functioning that can make the difference between a productive member of society and a misfit. Rodents would hardly appear capable of yielding such information to researchers. Better techniques for measuring and assessing non-carcinogenic risks must be found.

The future? Right now, things appear ominous. Aside from fears of nuclear war and world terrorism, we may well find ourselves in the midst of a chemical holocaust brought upon ourselves by bureaucratic incrementalism and corporate tunnel-vision.

After all, we are being asked to trust the same people who gave us DDT, Keypone, Dioxin, PCB's, EDB in our foods, asbestos in our schools and houses, DES to prevent miscarriages, UFFI, unvented gas heaters, tris flame retardant in children's sleepwear, hormones and antibiotics in our meat, pesticide residues in our food, and formaldehyde in our permanent press fabrics and paper towels. The list goes on and on. The same folks who are supposed to be guarding the barn keep shutting the door after each horse has been stolen. One after another.

Given our government's (hence our nation's?) clear lack of resolve in protecting public health, it is my opinion that the future will continue to bring us wave after wave of new chemical victims. As law librarians, you will be increasingly asked for assistance on toxic chemical issues. As you continue to build your expertise and collections on toxic torts and related matters, I hope that you will play a major role in directing chemical victims and their attorneys towards the resources they need in their quest for justice.

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The ECOLOGICAL ILLNESS LAW REPORT is an independent news-journal dedicated to providing news and analysis on the legal aspects of "ecological illness", a growing constellation of illnesses caused or exacerbated by chemical pollutants in the indoor, outdoor, and workplace environments. EILR will assist in the exchange of case information, and will send a complimentary copy to any attorney interested in the field of environmental hypersensitivity. Write to Earon S. Davis, Editor, Ecological Illness Law Report, P.O. Box 1796, Evanston, IL 60204-1796. Excerpts from Vol. III No.4/5 of the EILR appear on the following page(s). Thanks, Dr. Davis.

STUDY LINKS FOOD "ALLERGY" SYMPTOMS TO IMMUNE CHANGES

The results of a study of individuals suffering behavioral changes due to food sensitivities were reported at a recent meeting of the International College of Psychosomatic Medicine in Chicago. Dr. John Crayton, a psychiatrist and researcher at the University of Chicago, reported that 16 of 23 patients in his double blind study developed changes in their immune systems at the same time they developed symptoms such as depression, irritability, anxiety, and other behavioral changes, according to the CHICAGO TRIBUNE, Sept. 8, 1985 (section 4, page 14).

The study measured the effects of wheat, milk, and chocolate on individuals with a history of food "reaction" complaints involving mood change. The significance of these findings for "chemical" sensitivities is yet to be determined. However, it is likely that proof of an immunologic mechanism for food sensitivities (of a non-allergic nature) will provide an important link between chemically induced immune dysregulation and resulting food sensitivities. This study is an important benchmark in the ongoing effort to demonstrate that food sensitivities, a debilitating and extremely costly medical problem, can be caused by chemical exposures that damage the immune system.

PSYCHIATRIC TREATMENT OF THE ECOLOGICALLY ILL

As many EILR readers are aware, an article in the August 1983 issue of PSYCHOSOMATICS (24:731-7420) by Psychiatrist Carrol M. Brodsky, M.D., was entitled "Allergic to Everything: A Medical Subculture". Dr. Brodsky, who examined several people seeking workers compensation related to chemical sensitivities, found these people to have psychiatric problems. In the December 1984 issue of PSYCHOSOMATICS, Melvyn R. Werbach, M.D., took issue with the implication that chemical sensitivities do not exist.

In response to Dr. Werbach, Dr. Brodsky denied any "intent to make a global statement about allergic reactions to environmental substances". Brodsky went on to explain that the lack of allergic connections was the conclusion of the numerous specialists who examined the patients. This is a helpful clarification, especially since Dr. Brodsky's article has been cited to imply that ecological illness is psychological illness.

The letter by Dr. Werbach also includes a truism that bears repeating. "It would be just as regretable ... for psychiatrists to assume that all claims of environmental illness are merely functions maintained for dynamic reasons, as for clinical ecologists to assume that all psychiatric illness stems from hidden food and chemical sensitivities."

Another interesting article appeared in the June 1985 issue of PSYCHOSOMATICS, entitled "Pseudo-allergy: Treatment with a MAO Inhibitor". In this article, William Ulwelling, M.D., M.P.H., describes the use of specific medication to treat people who

claim to have food and chemical sensitivities. In fact, there is a legitimate concern in the treatment of individuals diagnosed as having chemical and/or food sensitivities for psychiatric illnesses they may experience, including depression and other affective disorders. However, one must remember that the diagnosis of a psychiatric disorder does not speak to the existence of ecological illness (either in general, or in the specific patient) since the psychiatric disorder may be a symptom of the chemically induced illness, a real-life, "normal" reaction to the difficulties of coping with these illnesses and the lack of acceptance among traditional physicians and others, or a separate illness entirely.

And what if a medication is successful in resolving the symptoms? There are several possibilities, including:
1. The symptoms happened to resolve by themselves at the same time.
2. The medication, by some unknown mechanism, worked.
3. The medication worked because the person was, in fact, suffering primarily from emotional, rather than ecological, illness.
4. The medication did not work, or
5. The medication appeared to work, but over the long term, it was no more effective than a "placebo", or
6. The medication appeared to work, but, in fact, it "masked" the patient's ecological illnesses and may cause additional immune damage and make it less likely that the chemical and food sensitivities can be diagnosed properly.

ALLERGY AND BEHAVIOR IN CHILDREN

According to the September 22, 1985 issue of the CHICAGO TRIBUNE, the American College of Allergists has released a report stating that as many as 10% of American children may suffer from a "newly identified" allergy syndrome. In this report, Dr. Gerald Klein said that children with common allergies may suffer from ill-behavior, irritability, temper tantrums, and decreased ability to concentrate. This report is, indeed, a very welcomed confirmation of what clinical ecologists and others have been condemned for stating in the past. While the report is solid evidence that traditional medicine is adopting the basic, medical premises of "clinical ecology", it also demonstrates how ignorant we are about the influences of allergy and toxicity on human behavior. From a consumer's perspective, it is frightening to see it takes 20, 30 or 40 years for a basic truth in medicine to be accepted by the medical profession. We simply cannot afford to wait so long. Perhaps the time will come when the skeptics will be the very ones to vigorously and insistently fight for prompt and adequate funding for research to demonstrate the truth or falsity of the claims. Under the present system, where the "burden of proof" rests with the proponent, and clinical medicine lacks major influence in Federal research programs, we will continue to see many sound ideas languish for years, only to be recirculated at some future date as "newly identified" truths.

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NONTOXIC & NATURAL: HOW TO AVOID DANGEROUS EVERYDAY PRODUCTS
by Debra Lynn Dadd

[Excerpts from the book reprinted with permission.]

LAUNDRY AGENTS: (ammonia, detergents, dyes, fluorescent brighteners, EDTA, ethanol, fragrance, isopropyl alcohol, napthalene, phenol.) "Caution: May be harmful if swallowed." "Warning: Harmful if swallowed, irritating to eyes and skin. Keep out of reach of children." (Some detergents with similar formulas have no warning on the label.)

SAFE ALTERNATIVES: Detergents were designed to clean synthetic fabrics. Natural fibers can be cleaned quite adequately with natural substances.

COTTON AND LINEN: Use borax, baking soda, washing soda, or a natural soap. Although most acids destroy the fiber, vinegar (acetic acid) can be used with no harmful effect. A drop or two of vinegar in the laundry water can help prevent colors from fading. Wash colors separately. Mildew grows easily on cotton fibers, especially if they are stored under damp and dark conditions. The fungus stains the fiber and eventually causes it to rot. To prevent mildew, which starts its growth on soiled clothes, keep clothing clean. Air clothes after wearing to allow any perspiration to dry, or wear clothes only once before laundering. Using borax with the laundry soap will help retard the formation of mildew. Leaving a light on in the closet can provide warmth to keep clothes dry and will inhibit mold growth even in wet weather.

SILK: Hand wash in very cold water with a mild or castile soap, swishing the fabric around for a few minutes and allowing the water to soak into the fabric. Do not rub. Rinse with cold water and gently remove excess water by rolling the fabric in a towel. Do not wring. Dry away from direct sunlight until damp, then press on the wrong side with a dry iron. A few drops of vinegar will help keep colors from fading without harming the fabric. White vinegar used in the final rinse will also help keep white silks white. Wash colors separately.

WOOL: Hand wash or delicately machine wash in lukewarm water (to prevent shrinkage) with mild soaps or diluted vinegar. Sweaters and knits should be reshaped to their original size while still damp. Do not use baking soda, as wool is quickly damaged by alkali. Dry cleaning of wool garments is not recommended because of the solvents used.

DRY CLEANERS: (ammonia, benzene, chlorine, detergents, formaldehyde, glycerin, naphthalene, paraffin, perchlorethylene, toluene, trichloroethylene, xylene.)

FABRIC SOFTENERS: (aerosol propellants, ammonia, colors, fragrance*, glycerine. "Caution: Keep out of reach of children." Fabric softeners are designed to reduce static cling in synthetic

fabrics and are unnecessary with natural fiber fabrics. If you must use fabric softener, choose an unscented brand. To make natural fiber fabrics softener, pour 1 cup white vinegar or 1/4 cup baking soda into the final rinse water to remove any scum left from natural soap.

*FRAGRANCE on a label can indicate the presence of up to 4000 separate ingredients that are not listed at all. Most or all of them are synthetic. Complaints to the FDA have included headaches, dizziness, rashes, skin discoloration, violent coughing and vomiting, and allergic skin irritation. Clinical observations by medical doctors has shown that fragrance can cause all types of central nervous system symptoms including depression, hyperactivity, irritability, inability to cope, and other behavioral changes.

AIR FRESHENERS: (aerosol propellants, colors, cresol, ethanol, formaldehyde, fragrances, isopropyl alcohol, napthalene, phenol, xylene.) "Air fresheners" work in one of several ways: interfering by way of a nerve-deadening agent with your ability to smell; coating the nasal passages with an undetectable oil film; deactivating the offensive odor or covering up the odor with another. Most air fresheners do nothing to freshen the air. They only add more pollutants.

SAFE ALTERNATIVES: Eliminate the need for air fresheners by keeping things clean. Putting an air freshener in a moldy closet will do nothing to solve the problem. The space must be kept dry and warm to prevent mold growth. Ventilate frequently. Open the windows throughout the house for at least a short period every day. This will not only keep the air smelling fresh, but will help reduce any buildup of toxic fumes that may be emitting from items in your home. Empty the garbage frequently and clean the can when needed. One-half cup borax sprinkled in the bottom of the garbage can will help inhibit the growth of odor-producing molds and bacteria. Keep damp kitchen and bathroom towels from mildewing by hanging them so they can dry thoroughly.

DO IT YOURSELF: Distribute partially filled bowls of baking soda or white vinegar discreetly around the room to absorb odors. Put herb mixtures in boiling water and continue to boil to release the natural scent. Make citrus pomanders: pierce a thin-skinned orange, lemon or lime with cloves (if the cloves break while trying to pierce the skin, make small holes with a toothpick first). When the entire fruit is covered, roll in a mixture of: 1 1/2 tsps orris root powder and 1 1/2 tsps ground cinnamon. Wrap with tissue and store in a closed drawer, cabinet or closet.

[NONTOXIC & NATURAL, a Guide For Consumers, is published by Jeremy P. Tarcher, Inc., and is available at your local bookseller or health food store. Our thanks to Debra Lynn Dadd.]

PHENOTHIAZINE DRUGS: FRIEND OR FOE?

by Douglas Steinke, B.Sc.

SCENARIO:

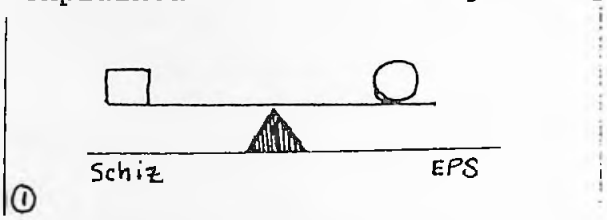
"Freedom! I had just become an outpatient of the hospital that I was admitted to for several weeks. The time went by slowly at first, but the last while went quickly. Everyone was very nice at the hospital, except nurse Kennedy. I don't trust her. I feel a lot better; the voices are gone and I don't have any more 'spells'. The doctor told me to go home and rest. He handed me a prescription and told me that I'd be feeling better in no time. As any diligent patient would do, I went to the drugstore to get my prescription filled. Nothing has changed in the store, every thing is pretty much the same. The pharmacist finally called my name and began telling me about my medication. Chlorpromazine (Largactil). The usual garble came out. Blah, blah, 2 tablets, blah, blah at bedtime. Then something I had never heard. 'With any medication you may have some adverse effects. I have given you a pamphlet with the medication. It will tell you more about what you're taking. Read it, and if there are any questions, just give me a call'."

"As soon as I got home, I fed the fish, watered some plants, and settled down to read this pamphlet I got with my pills. 'With this particular medication you may get some dizziness, therefore, get up out of chairs slowly. Drowsiness may occur, which will make operating heavy machinery hazardous. Avoid hot showers for they may make you dizzy. Do not drink alcoholic beverages with this medication. You may become sensitized to the sun. In this case, cover up, use a sun screen when outside. Your mouth may become dry. Suck on hard sugarless candy or crushed ice.' DO NOT ... PRECAUTION ... INTERACTION ... AVOID ... I sat back, and slowly began to panic!"

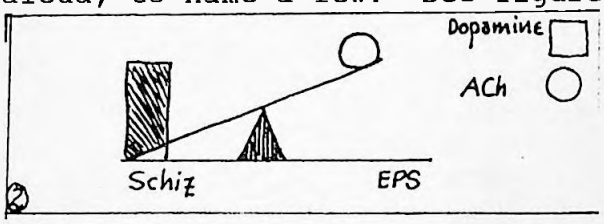
Although this scenario doesn't happen too often, it still may occur. Phenothiazine-type drugs, of which chlorpromazine is the prototype, are being used for certain types of schizophrenia.

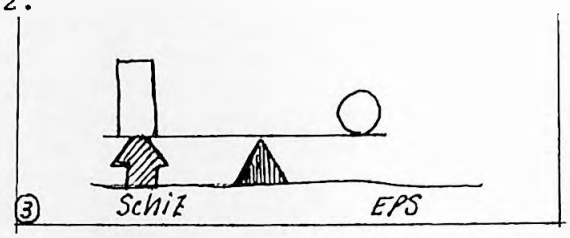
Phenothiazines have a particularly interesting history. The chemical was originally synthesized in 1883, but it was not until 1934 that it was first used as an antihelmintic (agent destructive to worms), antiseptic, and insecticide. The first report on the treatment of mental illness by chlorpromazine alone was made in 1952. In 1954, it was used for the first time in the Western Hemisphere as treatment for the manic states and hyperactive excitement. Soon thereafter, it was released onto the market, where it was used clinically as a drug to prevent vomiting, produce sedation, relaxation and hypothermia. Later, it was found to be useful in the treatment of psychotic states, and it has since been used primarily for psychiatric purposes.

Chemically, schizophrenia may be explained as a balancing act by neurotransmitters in the brain. In the normal patient, two chemical messengers, dopamine and acetylcholine (ACh) are in balance with each other. See Figure 1.



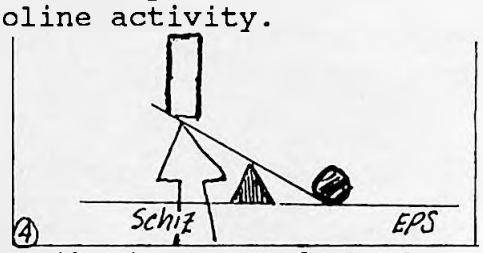
It is thought that in schizophrenic patients, dopamine is more active than acetylcholine in the brain. This increase in activity produces the psychoses: (e.g.) auditory hallucinations, suspiciousness, voices speaking to the patient, thoughts spoken aloud, to name a few. See figure 2.





In the brain, dopamine acts as a key. Sites on brain cells have specialized structures called receptors, which we can visualize as locks. If the key fits the lock, a reaction can take place. Too many reactions cause psychosis. Phenothiazines have the same key shape as dopamine, so that it too may fit in this lock on the brain cells. This interaction between drug and (lock) receptor does not cause a reaction. Instead, a competition for locks is set up, and the activity of dopamine in the brain decreases and is brought to normal by phenothiazines. See figure 3.

Drug induced extrapyramidal symptoms (EPS) occur when dopamine receptors are blocked by phenothiazines to a point at which the balance is tipped in favor of acetylcholine activity. (See figure 4) EPS may include: Psuedoparkinsonism (Parkinson's-like symptoms); Akathesia (inability to sit still, constant pacing); Dystonia (the tone of the muscles is no longer ordered - e.g. clenched jaw, twisting neck); Tardive Dyskinesia (repetitive, uncontrollable rapid movements of the mouth, tongue and cheeks).



The extrapyradimal symptoms are the most significant of the phenothiazine's side effects in terms of frequency, and reason for noncompliance with drug therapy. Psuedoparkinsonism has the same clinical signs and symptoms as Parkinson's disease. The only difference between the two is that psuedoparkinsonism is a decrease of dopamine due to blockade at the receptors and Parkinson's disease is a decrease of dopamine when neurons degenerate and die.

Early signs (or milder forms) of the illness consist of a reduction of facial movements and arm movements. The onset of psuedoparkinsonism symptoms is usually several weeks after the

neuroleptic drug is begun, and in some cases may be delayed as long as three months. Dystonic reactions occur within the first 72 hours of initial therapy, and may occur after only one dose. While psuedoparkinsonism tends to be more common in older females, dystonic reactions occur more often in younger males.

Akathisia is the most common and troublesome of all the EPS. It is often difficult to differentiate akathisia from psychotic agitation, and is least likely of all EPS to respond to treatment. When akathisia is misdiagnosed as psychotic agitation, it may result in an increase in drug dose, which in turn worsens the akathisia. It has no preference for age group, and its onset is usually several weeks after therapy. Akathisia may be the sole reason a patient is noncompliant.

Tardive Dyskinesia is a late-appearing effect which looks like an EPS but in most aspects is exactly opposite in the terms of the etiology (origin) of the disease and responsiveness to treatment. The mouth movements that are involved in this process are usually mild, and many patients are unaware of the movements until someone brings them to their attention. Tardive Dyskinesia often appears as if patients are chewing gum, or have ill fitting dentures. Several differences exist between it and the other EPS, in that it (a) often appears upon the dose reduction or withdrawal of phenothiazines, (b) improves when drug dosage is increased, (c) worsens when anticholinergic drugs are given, and (d) may persist for months or years after drugs are discontinued. Thus, it is seen that this condition can be very severe if not caught in time, and becomes irreversible.

What is the connection between phenothiazines and Parkinson's Disease? The answer lies in the mechanism by which they operate, i. e. the central concentrations of dopamine and their effects on the balance with acetylcholine. Both of these processes decrease the amount of dopamine. The slight difference is that phenothiazine EPS effects may be reversible, while Parkinson's disease is a degenerative disease.

Could it be that other agents, such as insecticides, that possess the ability to pass into the brain, may also affect these lock and key systems in the dopamine/acetylcholine balance? This is a difficult question to answer, because insecticides are not used in high concentration or for long periods of time, unlike drugs. The problem takes a new twist with the reactions that may occur in pesticide sensitive patients. There again, more research in this relatively new area must be done.

What happens to you and me in the meantime? This is a question that I pose to you, as your city sprays for insects in and around your neighbourhood.

"I sit back, and slowly begin to panic!"

* * * * * * *

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EDITOR'S NOTE:
Doug Steinke is an H.E.F. Canada member who has his B.Sc. in Environmental Chemistry, and is currently completing his fourth and final year as a student in the Faculty of Pharmacy, University of Manitoba in Winnipeg. He will be a licensed Pharmacist in May of 1986, and has promised to remain active as an environmentally aware and up-to-date, contributing columnist helping us to be 'educated consumers' in a chemically toxic world. In our June Quarterly, we'll feature a reprint/condensation of two articles Douglas did on organophosphate pesticides in March and June of 1985, along with a timely, thorough review of KNOW YOUR BODY (Neuroendocrinology For Beginners), referred to elsewhere in this edition.

* *

PHYSIOLOGY NOTES (reprinted from Vol. VII, No. 1, March 1985)

ACETYLCHOLINE (see KNOW YOUR BODY): ACh is a chemical transmitter released from many peripheral nerve endings (e.g. from postganglionic parasympathetic terminals of some sweat glands), and from some* neurons in the CNS. The postsynaptic peripheral receptors, and the central nervous system (CNS) receptors of importance* are called MUSCARINIC. In the preganglionic terminals (both parasympathetic and sympathetic), and in the motoneurons (lower motor) of the skeletal muscle endplates, the postsynaptic receptors are NICOTINIC.

ACETYLCHOLINESTERASE (AChE): an enzyme that breaks ACh down into acetic acid and choline; located near the acetylcholine receptors on the postsynaptic membrane. The function of AChE is to terminate the action of ACh at the junction of the various cholinergic nerve endings with their effector organs or postsynaptic sites. Chemicals that inhibit AChE are called ANTI-ChE (anticholinesterase) agents. They cause ACh to accumulate at cholinergic receptor sites and thus are potentially capable of producing effects equivalent to excessive stimulation of

cholinergic receptors throughout the peripheral and central nervous systems. (CHOLINERGIC: pertaining to a nerve fibre that releases acetylcholine; a compound that acts like ACh).

ANTICHOLINESTERASE AGENTS: can be absorbed through skin, lungs, and the gastrointestinal (GI) tract. Toxic effects are both (1) peripheral and (2) central.
(1) MUSCARINIC (increased bronchial secretions, bronchoconstriction, diarrhea) and NICOTINIC (muscular fasciculation and neuromuscular paralysis due to depolarizing block) are the commonly experienced peripheral effects.
(2) CENTRAL effects lead to respiratory depression, convulsions, and coma.

ORGANOPHOSPHATES: are anticholinesterases; irreversible, non-equilibrium antagonists; long lasting inhibitors that form a stable covalent bond with the AChE enzyme after about an hour (alkyl phosphorylation), at which time the bond becomes irreversible. More than 50,000 compounds (belonging to this group) have been synthesized. Some have a very high vapor pressure and are extremely toxic nerve gasses; the most potent synthetic toxic substances known. Others have a low vapor pressure, and are extensively used as insecticides. With some organophosphates (e.g. Parathion, but not Malathion), long term toxicity involving demyelination of nerves has been reported in agricultural workers. AntiChE agents as a group have extensive application as toxic agents, in the form of agricultural insecticides (e.g. Malathion) and potential chemical warfare 'nerve gasses'.

[THINK ABOUT IT!]

* *

"NEW" RESEARCH INTO AN OLD FOE?

THE FOOD-MOOD LINK: Dr. Wayne Callaway, endocrinologist and nutritionist at the Mayo Clinic, in Rochester, Minn., says: "There is no argument that diet affects mood. The big argument is HOW does it do it." Dr. John Crayton, an associate professor of psychiatry at the University of Chicago Medical Center, found a "significant" correlation between the ingestion of wheat and milk capsules, and changes of mood and behavior that included fatigue, depression, irritability and difficulty in thinking clearly, and said the immune-system changes suggested the food-mood link is not a traditional allergy, but another sort of immune reaction in which "the body is trying to neutralize the food; trying to create an antibody to it." [NEWSWEEK, Oct.14/85]

"In the field of problems which appear to be mental or emotional, which Randolph had first successfully treated in the late 1940s and early 1950s, the Chicago allergist offered a perfectly scientific, rational, and cogent approach - and was almost completely ignored by the psychiatric profession." [Introduction: Drs. Theron G. Randolph and Ralph W. Moss's AN ALTERNATIVE APPROACH TO ALLERGIES, November 1980.]

ALLERGIC REACTION (Vancouver Province, Oct. 2, 1985)
(UPI) Children who are labeled as brats or emotionally disturbed may actually have allergies, according to a report by the American College of Allergists. Dr. Gerald Klein, author of the report, says cranky children may actually be suffering from "allergic irritability syndrome" caused by reactions to substances such as mould, pollen or dust. Klein says the syndrome also affects adults, but they are more likely to identify what's making them irritable and are better able to cope with it. Klein became aware of the syndrome several years ago while treating a six-year-old boy who was disruptive at home and school. Klein says the child's behavior turned around after doctors treated his allergies. [I wonder if he's read Dr. Theron Randolph's books and publications of the past 40 years? MMN]

CONSUMERS HEALTH ORGANIZATION OF MANITOBA (CHOM) is holding their "HELP YOURSELF TO HEALTH" EXPO '86 at the Winnipeg Convention Centre on March 15, 1986. Among the prominent guest speakers: Dr. Earl Mindell, R.Ph., Ph.D., (Winnipeg born) author of the best selling 'Vitamin Bible' and three other books, and Dr. Marshall Mandell, M.D., author of the '5 Day Allergy Relief System' (among others). Dr. Mandell's lecture topic will be 'Allergies, Arthritis and M.S.' [Many thanks to Elizabeth Logan for keeping us informed, and to the CHOM NEWSLETTER for allowing us to reprint the following letter published in the Winnipeg Free Press on March 9, 1985, and pertinent today, here, as we all wonder about the fate of the Thomson Report, and the future of ecologically ill patients, clinical ecologists, and the medical "establishments" and colleges across Canada. MMN]

ENFORCING ORTHODOXY (Letters To The Editor)

The article DOCTORS PRESSURE COLLEAGUE refers to Dr. Leo Cruikshank "backing out" of a scheduled lecture at the Help Yourself To Health Expo (1985) and states that the sponsors (CHOM) said the College of Physicians and Surgeons "forbade the speech" (the college said it merely "discouraged" him). Dr. Cruickshank personally phoned me cancelling the presentation, and said that he was "forbidden to speak" following a meeting of the college executive, which "controls the licensing". It was my impression that he had no choice in the matter if he wished to protect his licence. This is a dangerous precedent that will no doubt inhibit other M.D.'s who are sympathetic to the holistic movement (and there are many) from accepting any speaking engagements not sanctioned by the college for fear of this apparent extended power now being wielded by the college in the area of "freedom of speech", as expressed by Joe Campbell, Ph.D., (then) vice-president of CHOM.

Dr. Morison (registrar of the college) is quoted as saying "We convinced (Cruikshank) it was very unwise to give credibility to unproven theories and the presence of a medical doctor (at a conference on alternative medicine) would imply an endorsement." The ultimate irony of this statement is that Dr. Cruikshank's topic was to be 'Alternative Methods of Pain Control' that he

himself recommends or prescribes at the Pain Control Clinic - which he originated in 1971 - at the Health Sciences Centre. Some of these methods are used in holistic medicine and are "unproven". I believe he includes acupuncture, hypnosis, relaxation techniques, biofeedback, reflexology, some non-drug medications, etc., in his repertoire.

Furthermore, the pain clinic only accepts patient referrals from other medical doctors who failed with their so-called "proven" methods and Dr. Cruikshank proceeds to treat them, usually successfully, using many of these unproven theories. His philosophy would seem to be: if it works, use it. Why wait for science to prove it?

All proven methods were once unproven theories, and many proven drugs have become unproven or banned. In addition, some conventional treatments (e.g. surgery) are not and cannot be proven by the double blind system, as are many alternative therapies based on bioenergy concepts (Oriental, spiritual). Yet they have worked for centuries.

Dr. Kurt W. Donsbach, Ph.D., chairman of the National Health Federation in the United States and one of the feature speakers at the (1985) health expo said:

"The gap between what is known and well-documented regarding the role of holistic practices in disease prevention and therapy and what has been incorporated into clinical medical practice is staggering. Perhaps this gap is also a tribute to the power of the drug and surgical supplies industry, whose dollars, channeled through foundations that dispense grants for medical research and education, have dominated those fields to the exclusion of other forms of treatment. The basic concepts of the holistic practitioner are often at odds with the very goods that make money for this industry. From their perspective, in fighting the holistic movement, they're simply protecting their right to make a profit." Unfortunately, the health consumer is the loser.

(signed) Elizabeth Logan
Consumers Health Organization of Manitoba
CHOM, Box 2514, Winnipeg MB R3C 4A7

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W H A T Y O U D O N ' T K N O W C A N H U R T Y O U
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POOR COMMUNICATION BLAMED FOR PROBLEMS OF ASTHMATIC/ALLERGIC CHILDREN IN SCHOOLS (The Annals of Allergy, June 1985): The American College of Allergist's (ACA) Committee on allergy problems in school settings reports that many of the problems confronting asthmatic and allergic children at the school could be reduced or eliminated. In a survey of ACA members in the U.S.A., about 300 of the sampled group responded with 80% reporting a "significant problem" arising because of the schools' unwillingness to make provision for allergic/asthmatic children to receive the medications they need. This, they suggested, increases both illness and absenteeism. About 75% of the respondents said that misinformation circulating among school

personnel and physicians about allergic disorders contributes to excessive absences of asthmatic/allergic children. About six specialists in seven said that asthmatic children "may perform poorly in school" or are "unjustly penalized or pushed beyond their capacity in physical education" because of such misinformation. The issues discussed by the committee include: (1) children are sent home because allergies are mistaken for upper respiratory diseases; (2) school personnel are unaware of the side effects of allergy/asthma medications and how these and the disorders themselves impact on a student's learning and behavior; and are (3) unfamiliar with the allergic child's need to avoid classroom allergens and irritants such as animals, chalk dust, perfumes and certain foods which can trigger symptoms. [Thanks to G. Joy Underwood, Allergy Consultant and Editor of THE HEALTHY LIVING REPORTER, 1202-1175 Broadview Ave., Toronto, Ont. M4K 2S9. We'll have more from Joy Underwood in our next issue.]

PARENTS OF ENVIRONMENTALLY SENSITIVE (PES) President Margaret Nikiforuk and Director C. Mills met with Judge George Thomson on June 12, 1985 to re-state their concerns and advance new proposals before the Committee on Environmental Hypersensitivity Disorders completed their report. Their concerns and proposals were published in the PES NEWSLETTER of July, 1985, and bear repeating here:

(1) PES continues to recommend a multi-disciplinary committee for a very complex disorder, as diversified knowledge is needed to protect the patient, and the following disciplines are suggested: experienced patients and experienced and involved families; clinical toxicologist; research toxicologist; clinical immunologist; geneticist; nutritional therapist; physicians who have had adequate experience treating these patients; alternate therapists, i.e. Naturapaths, Acupuncturists, Chiropractors who are experienced in the treatment of these patients; preventive advisors, i.e. Public Health Nurses experienced in counselling these families.

(2) PES recommends that education programs be established for health personnel, school boards, general public to facilitate and coordinate assistance for the seriously ill, develop prevention programs, etc. Astronomical funds have been allocated for AIDS. We recommend the same for the study of Environmental Hypersensitivity.

(3) Further recommendation was that hypersensitivities be made reportable and thereby the prevalence will be eventually known.

(4) Recommended establishment of a "slush fund" to provide immediate financial assistance for the critically ill. If liver transplants ($135,000 U.S. funds) can be funded, surely $25,000 to $35,000 or whatever the costs to assist the critically ill environmentally sensitive patient should be allowable.

(5) PES remains concerned that terms of reference by Ministry of Health Committee did not consider the immediate plight of the

critically ill patients. The terms of reference listed as Methods of Diagnosis, Incidence of the Disease and Treatment Modalities appear to be issues for the Medical profession. Methods of Diagnosis have been established in treatment centres in many countries. Treatment modalities appear to be a red herring as treatment for many illnesses, i.e. cancer, arthritis, etc. may not be successful, but are still being used.

(6) PES believes that like cancer, until a cure is found, the environmentally sensitive must be given a chance to fight for their lives using the methods most helpful to them.

(7) We believe that the illness is manmade - iatrogenic, and in all probability involves the immune system. Therefore, we recommend that the Provincial government ban use of herbicides and pesticides since they are known to damage immune systems.

(8) Recommendations by the patients' doctor of choice should be acknowledged for disability pensions, special diets, nutritional supplements, special housing and services, etc.

(9) Our chief concern remains that the health needs and suffering of these patients continue to be overlooked by the inadequacies of our present health care system.

PARENTS OF ENVIRONMENTALLY SENSITIVE (PES), Box 434, Station R, Toronto, Ontario M4G 4C3 [P.E.S. and its President, MARGARET NIKIFORUK, deserve the loudest BRAVO of all! It was their fighting spirit, faith, and determination that provided the catalyst needed to make the Thomson Report more than a hope or need. Today it's a reality ... an opened door ... a realization and acceptance of the FACT: WE EXIST! BRAVO, and THANK YOU!]

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THE H.E.F. CANADA QUARTERLY WELCOMES YOUR CONTRIBUTIONS!
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*BETTER TO LIGHT A CANDLE THAN TO CURSE IN THE DARK *
* *

E D I T O R I A L C O M M E N T

FLASHBACK: A conversation overheard while waiting for a traffic light to change near an allergy clinic several blocks from my own. It wasn't one of my good days. I'd had dental work done (lidocaine/fluoride), hit a long stretch of construction on my walk downtown (heavy machinery exhaust, tar and dust), got caught in a traffic jam waiting to cross a major street and bridge enroute (car exhaust, diesel fumes), and taken a moment to wonder if I was going to make it all the way to where I was going. I was severely edemic. My feet were blistering. I could smell the overpowering aura of ammonia that seems to envelope me when I'm hitting "overload". I was exhausted, depressed, confused, and hyperactive. Mood-swinging in my mind, caught in cerebral and physical allergy/hypersensitivity manifestations, I was relieved that the staff in "my" clinic would see me and KNOW what I was going through. I was dizzy, nauseated, headache-y; despite the inch thick cotton mask I held firmly against my nose and mouth. I was, at the moment I became aware of the conversation, feeling very sorry for myself. That soon changed as I realized the two women behind me were talking about ALLERGIES. One was obviously a veteran, and spoke of her frequent visits to psychiatrists at the urging of her allergist. The other was newly diagnosed, more than a little frightened, and had (she said with some surprise at the coincidence) recently been urged by her allergist to see a psychiatrist for her depression, irritability, anxiety attacks, and the aches and pains he didn't believe she had. I couldn't resist it. I turned, took the mask from my face, grinned and said: "They always tell allergic women to see psychiatrists. It's called 'The Bored Housewife Syndrome'. Sick children? Did you fight with your husband this morning? Do you hate your mother?" We all laughed, but deep inside, I know none of us really found it amusing, because it's too often true. It amazes me that so many professional physicians and psychiatrists are so far behind the research now available, that they continue to perpetuate the myth that it is "all in our minds", and treatable with mind-altering drugs. As a result of years spent studying anatomy and physiology (and, thanks to soon-to-be-pharmacist and my chemistry/pharmacology teacher Doug Steinke), particularly concentrating on the areas of the brain most affected by antipsychotic, antimuscarinic and anticholinergic drugs, I am struck (once again) by the similarities between the symptomatology of psychoses, and the symptomatology of my cerebral "allergic" hyper-reactions to foods, drugs, fabrics, chemicals, and environmental assaults (e.g. pesticide spraying in and around my neighbourhood). Pain? I know it intimately. It is not my intention to get psychiatrists as upset with proponents and practitioners of clinical ecology as the medical people seem to be, but WE'RE NOT CRAZY, WE'RE SICK! Many of us would be happy to assist doctors by doing double-blind clinical testing in ecology units, but we need financial assistance. WE ARE AN ENDANGERED SPECIES. We are YOUR species. Please stop fighting amongst yourselves, and HELP US TO SURVIVE.

Your faithful Editor, Mary Merlin Nelson

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